MONTICELLO SCHOOL DISTRICT
STUDENT HEALTH/EMERGENCY INFORMATION SHEET

Student's Name:______________________________ **Grade:**_________ **Date of Birth:**______________

Parent To Contact:______________________ **Cell#**________________ **Home#**____________________

Second Name To Contact:____________________ **Cell#**________________ **Home#**____________________

Relation To The Student____
Please notify the school if your contact information changes throughout the year.
It is important for the nurse to have a working number if your child becomes ill or injured at school.

⇉*Permission to Administer Over-the-Counter Medications*⇇

Antibiotic ointment, anti-itch cream, antiseptic spray, rewetting eye drops/contact solution, cooling burn gel, blistex/vaseline,sunscreen, hydrogen peroxide, alcohol prep pads, bee sting swabs, dental wax, orajel

Parent Signature:____

Transportation: Car_____________ **Bus**______________

List Any Physical Challenges Your Child May Have:____

List Medical Conditions Or Diagnosis Regarding Your Child:____________________________________

Medications: (Please list all medication that your child is taking.)__________________________________

____

Will your child need an inhaler at school? _________ **yes**______ **self-carry**
_________ **no**

If your student requires medication to be given at school, please see the School Nurse for appropriate paperwork.
A doctor's order must accompany all medications to be given at school.
Emergency meds are provided to the school by the parent. Students can self-carry inhalers/epipens with a doctor's signature of approval. Please see the School Nurse for the appropriate paperwork.

List Any Known Allergies:

Food:________________________________ **Epipen required:**___________

Medication:____

Environment:__________________________ **Epipen required:**____________

Insects/Wasps/Bees:______________________ **Epipen required:**____________

☞ ***PLEASE FILL OUT THE BACK*** ☜

RELEASE OF MEDICAL INFORMATION: I hereby understand and authorize that my child's medical records or any other medical information, furnished to the school, will be shared with school officials and/or emergency personnel who have a legitimate medical/educational purpose for accessing such medical records and information. Monticello School District will abide by the Health Insurance Portability and Administrative Act (HIPPA)Law as it pertains to student medical records. Students' health records will be maintained in a secure area to prevent intentional and unintentional disclosure of protected information. By signing this Notice, I acknowledge receipt of this policy.

PARENT'S SIGNATURE:_______________________________ DATE:______________

In compliance with the Family Education Rights and Privacy Act (FERPA), I give permission for my child's personally identifiable information/student education records to be disclosed to a Third Party billing Agent for the purpose of billing Medicaid and/or private insurance.

PARENT'S SIGNATURE:_______________________________ DATE:______________

In compliance with the Family Education Right to Privacy Act (FERPA),I give permission for my child to participate in the School Immunization Clinic. I understand that the appropriate Arkansas Department of Health consent forms will be provided for my consideration prior to the clinic.

PARENT'S SIGNATURE:_______________________________ DATE:______________

PARENTAL CONSENT FOR MEDICAL DENTAL/ TREATMENT

A signed release form will be needed in the event of an emergency situation requiring medical or dental treatment or non-emergency situation when such treatment (or diagnosis) is advised by a licensed physician or dentist to be in the best interest of the student and when the parent or guardian cannot be contacted. The undersigned hereby authorizes the Monticello School District to obtain medical or dental treatment from a licensed physician or dentist for:

Legal Name of Student ______________________ Date of Birth ______________________

The undersigned further agrees that the Monticello School District will not be held liable for financial liability or for injuries sustained of such medical or dental treatment.

This consent shall remain effective during the 2021-2022 school year, unless sooner revoked in writing and delivered to your child's principal who is entrusted with the custody, care and control of said minor child.

Parent/Legal Guardian's Signature:_______________________________________

Home Address:_______________________________________

Name of Family Physician:_______________________________________

Name of Personal Insurance:_______________________ Policy Number:______________

Health Screenings- Please sign if you **DO NOT** want your child to receive the following screenings:

______ BMI K, 2, 4, 6, 8, &10

______ Scoliosis Girls grades 6&8, boys grades 8 only

Parent Signature:_______________________________ Date:______________