North Andrew R-VI
Enrollment, Health, Emergency & Permission Form

STUDENT INFORMATION:

Student's Legal Name: First _____ Middle _____Last _____
Grade: _____ Social Security Number: _____ Date of Birth: _____
Student's Primary Language: _____ Male: _____ Female: _____

PARENT INFORMATION:

Primary Parent/Guardian Name: _____
____Mother ____Father ____Step-Mother ____Step -Father ____Guardian ____Foster Parent ____Host Parent
Home Phone: (____)_____ Cell Phone: (____)_____Email: _____
Address: _____ City _____ State _____ Zip_____
Employer Name: _____ Work Phone: (____)_____ (Ext)_____

Primary Parent/Guardian Name: _____
____Mother ____Father ____Step-Mother ____Step -Father ____Guardian ____Foster Parent ____Host Parent
Home Phone: (____)_____ Cell Phone: (____)_____Email: _____
Address: _____ City _____ State _____ Zip_____
Employer Name: _____ Work Phone: (____)_____ (Ext)_____

Other Parent – Not in the Home: _____
____Mother ____Father ____Step-Mother ____Step -Father ____Guardian ____Foster Parent ____Host Parent
Home Phone: (____)_____ Cell Phone: (____)_____Email: _____
Address: _____ City _____ State _____ Zip_____
Employer Name: _____ Work Phone: (____)_____ (Ext)_____

If divorced, who has legal custody? ____ Mother ____ Father

WHERE WILL YOUR CHILD GO IF SCHOOL GETS OUT EARLY? _____

IN CASE OF EMERGENCY CALL: ***(Persons whom you give permission to check out or pick up students for appointments, illness or emergency)***
******Must not be a current student and must be over the age of 18******

Name_____Phone_____
Name_____Phone_____
Name_____Phone_____
Name_____Phone_____

In the event that your child has an accident or becomes ill at school, please list the physician to be called.

Physician_____Phone_____

Dentist_____Phone_____

Date of Last Physical ____/____/____ Last Tetanus Shot ____/____/____ Last Dental Check –up ____/_____/_____

My child has permission to have vision, hearing,dental, speech/language, etc. screening test YES _____ NO_____

PRESENT HEALTH CONDITIONS:

Bee Sting Allergy Yes_____No_____Describe reaction_____
Difficulty breathing? Y___N___ Emergency medication needed? Y___N___
If YES Bee Sting allergy form must be completed

Food Allergy Yes_____No_____ To what? _____
Difficulty breathing? Y___N___Emergency medication needed? Y___N___
If YES Food allergy form must be completed

Asthma Yes_____No_____Triggered by_____
Treatments_____
Diagnosing Dr. name _____ Phone# _____
If YES Asthma care plan form must be completed

OVER

Other Present Health Concerns _____

_____

Diabetes YES / NO Epilepsy/Seizure Disorder YES / NO Heart Condition YES / NO Bone/Joint Condition YES / NO

If yes to any of the above illnesses please be specific about condition below.

Past Medical History (Injuries, Hospitalization/Operation, Health Problems) _____

_____

List any other allergies your child has (Medications , environmental, etc.)._____

_____

List any medications and dosage your child currently takes _____

_____

We have the following medications available at school to treat minor illness/injuries. **If you prefer your child not to receive one of these or he/she has an allergy, please indicate in the space below.** We must have a parents/guardians signature at the bottom of this page before we can give any medication.

***Generic versions may be used.**	*Campho-phenique	*Tylenol	*Eye Wash/Artificial Tears/Visine
*Epi-pen (severe allergic reactions.)	*Vaseline/Blistex	*Ibuprofen	*Similasan Ear Drops
*Albuterol(severe asthma episode)	*Solarcaine Spray	*Cough Drops	*Anbesol/Oragel/Orasol
*Benedryl (minor allergic reactions)	*Aloe Vera	*Robitussi n	*Vick's Vapor Rub
*Caladryl/Calamine Lotion	*Triple Antibiotic Ointment	*Tums	*Chloroseptic
*Hydrocortisone 1% Cream	*Peroxide	*Sore Throat Lozenges	*Wound cleansers/Saline

*Decoral Forte (Acetaminophen, Dextromethorphan, Guaifenesin, Phenylephrine) * Medicidin-D (Acetaminiphen, Chlorpheniramine Maleate, Phenylephrine)

Regarding Epi-Pen **PLEASE NOTE::** Epi-Pen administration is Board approved and WILL BE ADMINISTERED IN THE EVENT OF AN ANAPHLYACTIC REACTION (which is an emergency).

Please list any items above you do not want your child to have: _____

_____

Authorization is given to North Andrew R-VI to consent to medical treatment for my child _____ if we the parents/guardians are not available at the time of injury/illness. Our private physician or a consulting physician of his/her choice recommends admission to the hospital; we authorize admission to any hospital for our child at the time of an injury/illness in our absence. We, the parents/guardians, will be responsible for the charges for any medical treatment or hospitalization rendered by reason on this authorization.

Insurance Company & Policy # _____

Missouri Health Net/Medicaid # _____

_____ **Please mark if you do not have Insurance.**

Legal Signature of Parents/Guardians:

Consent for Medical Treatment must be **signed in the presence of** a notary public. (One signature required, two recommended.)

Signature_____

Signature_____

Subscribed and sworn to before me this _____day of _____, 20___.

_____

Notary Public

If you do not get this form SIGNED and NOTORIZED the health office cannot treat your child with any medication!