Dieringer School District

Health Report

2008-09

Please provide the following information to better enable the school district employees to care for your child. This information is confidential but will be shared on an as-needed basis with teachers, playground supervisors and health/administrative staff.

Student Name:_____ **Birthdate:** _____**Grade**____
Last First Middle Name

Address: _____ **Home Phone:** _____
Parent/Guardian: _____ **Daytime Phone:** _____
Cell Phone: _____

Parent/Guardian: _____ **Daytime Phone:** _____
Cell Phone: _____

Does your student have any health condition we need to know about at school? Yes___ No____
If yes, please explain: _____

Specifically, does your student have any of the following conditions?

____Asthma
____Diabetes
____Seizures
____Stomach or bowel difficulties
____Kidney or bladder difficulties
____Frequent ear infections/tubes
____High blood pressure
____Heart problem
____Skin problem
____Vision loss
____Wears glasses
____Hearing loss or hearing aides
____Attention Deficit with or without hyperactivity
____Frequent Nosebleeds
____Speech disorder
____Other: _____

Allergies (please list):_____

Explain any problems, issues or recent changes, including learning disabilities:

_____

_____

Does your student take routine medications of any kind? Please explain and include all medications even if not taken at school. _____

*****A written doctor's order and written parent consent are required by law for any medication to be given at school. This includes prescription as well as over-the-counter medications such as Tylenol or cough drops. Contact school for appropriate forms.*

Authorization for Emergency Procedure**:**

I understand that the school is not responsible to care for my student if he/she is ill and unable to attend classes. I will make every effort to pick up my student immediately upon notification or I will make arrangements with another responsible adult for my student's care. If I cannot be reached at the time of a serious illness or injury, school authorities have my permission to seek necessary emergency treatment and to transport my student (properly accompanied) to the most easily accessible healthcare facility. I understand that I will assume full financial responsibility for any services rendered.

Parent Signature: _____ Date: _____