REED-CUSTER Health History & Parental Consent

Student: _____ DOB: _____ School Year: _____

School (circle one): RCPS RCIS RCMS RCHS Grade: _____ Teacher: _____

Only list a phone number once! Mom/Guardian Cell: _____ Dad/Guardian Cell: _____

Home phone: _____ Mom/Guardian Work: _____ Dad/Guardian Work: _____

Parent/Guardian & Phone(s): _____

Physician & Phone: _____ Last exam: ____/____/_____

Dentist & Phone: _____ Last exam: ____/____/_____

KNOWN ALLERGIES: _____

The health of your child is one of the most important factors in his/her school progress; therefore, we request that you assist by providing us with the following health information. This information will be held in strict confidence.

HISTORY: Check ☑ all that apply	
Allergies	☐ seasonal ☐ medication ☐ insect ☐ environmental ☐ antihistamine (local) ☐ food ☐ dietary restrictions ☐ reaction ☐ epi-pen (life-threatening)
Asthma	☐ mild ☐ moderate ☐ severe ☐ inhaler ☐ breathing treatment
Cardiac Condition	*Explain:*
Diabetes	☐ Type I ☐ Type II ☐ insulin monitor
Seizures	*Explain:*
Dental Problems	☐ braces ☐ root canals ☐ spacer ☐ false teeth
Hearing/Speech Problems	☐ known loss ☐ hearing aids ☐ frequent ear infections ☐ speech therapy
Kidney/Urinary Problems	☐ infections ☐ surgery
Skin Conditions	☐ eczema ☐ psoriasis
TB/TB contact	☐ yes
Vision Problems	☐ glasses ☐ contacts ☐ surgery
Birth Defects	*Explain:*
Developmental Delay	*Explain:*
Restrictions	☐ PE/modified PE ☐ dietary restrictions ☐ weather related
Special Services	☐ IEP ☐ 504 Plan
Hospitalizations/Surgeries	*Explain:*
Medication (at home)	*Explain:*

Terms for Administering Medication to Reed-Custer CUSD 255 Students

1. As parent or guardian, I am responsible for administering medication to my child. However, in the event that I am unable to do so, or in the event of an emergency, I hereby authorize Reed-Custer CUSD 255 and its employees and agents, in my behalf and stead, to administer, or attempt to administer to my child (or allow my child to self-administer, while under the supervision of the employees and agents of the School District), lawfully prescribed medication in the manner described on the Physician's Medical Orders (on reverse side). *I ACKNOWLEDGE THAT IT MAY BE NECESSARY FOR THE ADMINISTRATION OF MEDICATIONS TO MY CHILD TO BE PERFORMED BY AN INDIVIDUAL OTHER THAN A SCHOOL NURSE, AND SPECIFICALLY CONSENT TO SUCH PRACTICES.*

2. When the lawfully prescribed medication is so administered, I waive any claims I might have against the Reed-Custer CUSD 255 School District, its employees and agents arising out of the administration and agents, either jointly or severally, from and against all claims, damages, causes of action or injuries incurred or resulting from the administration or attempts at administration of said medication. NOTE: Parent/Guardian signature must be on file, agreeing to these terms, before any medication will be dispensed at the School District.

I have read and agree to all the terms outlined on this form and hereby give my child's school permission to supervise the administration of the medication(s) listed on the reverse side of this form and permission to call the doctor or pharmacist as needed.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

Please circle your response and sign: (I do / I do not) give the School Nurse my permission to share information relevant to my child's medical status with school staff on a "need to know" basis, if she/he determines that this information is necessary to assure my child's health and safety.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

REED-CUSTER

Physician's Medical Orders

Student: _____ DOB: _____ School Year: _____

School (circle one): RCPS RCIS RCMS RCHS Grade: _____ Teacher: _____

Parent/Guardian & Phone(s): _____

Physician & Phone: _____

KNOWN ALLERGIES: _____

☐ ANNUAL EMERGENCY ACTION PLAN REQUIRED FOR:

Required forms available at: www.rc255.net ☐ N/A

☐ Asthma ☐ Cardiac Condition ☐ Diabetes ☐ Food Allergy/Anaphylaxis ☐ Seizures

Health Practitioner Signature: _____ Date: _____

☐ PHYSICIAN'S AUTHORIZATION FOR MEDICATION:

Prescribed or OTC medications given at school require doctor's orders. ☐ N/A

Indicate whether Rx or OTC	Medication Orders	Dosage (Qty.)	Frequency (Time)
☐ Rx ☐ OTC	_____	_____	_____
☐ Rx ☐ OTC	_____	_____	_____
☐ Rx ☐ OTC	_____	_____	_____

Mark all that apply:

- ☐ I understand that this medication may be given by school personnel other than a certified nurse.
- ☐ This medication may be self-administered and carried by the student under supervision.
- ☐ This INHALER medication may be self-administered and carried by the student.

Health Practitioner Signature: _____ Date: _____

☐ PHYSICAL EDUCATION RESTRICTION ORDERS:

(i.e. weight training restrictions) ☐ N/A

☐ Exercise precautions – Explain: _____

☐ Modified PE – Explain: _____

☐ Other parameters – Explain: _____

Health Practitioner Signature: _____ Date: _____

☐ OT/PT PRESCRIPTION ORDERS:

☐ N/A

☐ School based OT/PT services are recommended, as a result of an evaluation performed in the school setting.

☐ Relevant diagnosis must be provided by the physician for services to be initiated.

☐ Diagnosis: _____

☐ List or attach precautions: _____

Treatment Plan:

- ☐ OT evaluates and treats as appropriate for school-based goals.
- ☐ PT evaluates and treats as appropriate for school-based goals.

Health Practitioner Signature: _____ Date: _____

THE PHYSICIAN OR PARENT MAY FAX THIS COMPLETED FORM TO THE APPROPRIATE SCHOOL AT THE FAX NUMBER BELOW.

Reed-Custer Primary School (EC-1st)	815-458-4147	Reed-Custer Middle School (6th-8th)	815-458-4118
Reed-Custer Intermediate School (2nd-5th)	815-458-4039	Reed-Custer High School (9th-12th)	815-458-4138