



Student: _____ DOB: _____ School Year: _____

School (circle one): RCES 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	<input type="checkbox"/> seasonal <input type="checkbox"/> medication <input type="checkbox"/> insect <input type="checkbox"/> environmental <input type="checkbox"/> antihistamine (local) <input type="checkbox"/> food <input type="checkbox"/> dietary restrictions <input type="checkbox"/> reaction <input type="checkbox"/> epi-pen (life-threatening)
Asthma	<input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> severe <input type="checkbox"/> inhaler <input type="checkbox"/> breathing treatment
Cardiac Condition	Explain: _____
Diabetes	<input type="checkbox"/> Type I <input type="checkbox"/> Type II <input type="checkbox"/> insulin monitor
Seizures	Explain: _____
Dental Problems	<input type="checkbox"/> braces <input type="checkbox"/> root canals <input type="checkbox"/> spacer <input type="checkbox"/> false teeth
Hearing/Speech Problems	<input type="checkbox"/> known loss <input type="checkbox"/> hearing aids <input type="checkbox"/> frequent ear infections <input type="checkbox"/> speech therapy
Kidney/Urinary Problems	<input type="checkbox"/> infections <input type="checkbox"/> surgery
Skin Conditions	<input type="checkbox"/> eczema <input type="checkbox"/> psoriasis
TB/TB contact	<input type="checkbox"/> yes
Vision Problems	<input type="checkbox"/> glasses <input type="checkbox"/> contacts <input type="checkbox"/> surgery
Birth Defects	Explain: _____
Developmental Delay	Explain: _____
Restrictions	<input type="checkbox"/> PE/modified PE <input type="checkbox"/> dietary restrictions <input type="checkbox"/> weather related
Special Services	<input type="checkbox"/> IEP <input type="checkbox"/> 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:** _____



Student: _____ **DOB:** _____ **School Year:** _____
School (circle one): RCES RCMS RCHS **Grade:** _____ **Teacher:** _____
Parent/Guardian & Phone(s): _____
Physician & Phone: _____ **Fax:** _____
KNOWN ALLERGIES: _____

<input type="checkbox"/> ANNUAL EMERGENCY ACTION PLAN REQUIRED FOR:	Required forms available at: www.rc255.net	<input type="checkbox"/> N/A
<input type="checkbox"/> Asthma <input type="checkbox"/> Cardiac Condition <input type="checkbox"/> Diabetes <input type="checkbox"/> Food Allergy/Anaphylaxis <input type="checkbox"/> Seizures		
Health Practitioner Signature: _____		Date: _____

<input type="checkbox"/> PHYSICIAN'S AUTHORIZATION FOR MEDICATION:	Prescribed or OTC medications given at school require doctor's orders.	<input type="checkbox"/> N/A																
<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 20%; text-align: left; font-size: small;">Indicate whether Rx or OTC</th> <th style="width: 30%; text-align: center; font-size: small;">Medication</th> <th style="width: 20%; text-align: center; font-size: small;">Dose/Frequency</th> <th style="width: 30%; text-align: center; font-size: small;">Diagnosis</th> </tr> </thead> <tbody> <tr> <td style="font-size: small;"> <input type="checkbox"/> Rx <input type="checkbox"/> OTC </td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td style="font-size: small;"> <input type="checkbox"/> Rx <input type="checkbox"/> OTC </td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td style="font-size: small;"> <input type="checkbox"/> Rx <input type="checkbox"/> OTC </td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> </tbody> </table>	Indicate whether Rx or OTC	Medication	Dose/Frequency	Diagnosis	<input type="checkbox"/> Rx <input type="checkbox"/> OTC	_____	_____	_____	<input type="checkbox"/> Rx <input type="checkbox"/> OTC	_____	_____	_____	<input type="checkbox"/> Rx <input type="checkbox"/> OTC	_____	_____	_____		
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Mark all that apply: <ul style="list-style-type: none"> <input type="checkbox"/> I understand that this medication may be given by school personnel other than a certified nurse. <input type="checkbox"/> This medication may be self-administered and carried by the student under supervision. <input type="checkbox"/> Attach a copy of the student's user card and the caregiver's card for cannabis order. 																		
Health Practitioner Signature: _____		Date: _____																

<input type="checkbox"/> PHYSICAL EDUCATION RESTRICTION ORDERS:	(i.e. weight training restrictions)	<input type="checkbox"/> N/A
<input type="checkbox"/> Exercise precautions – Explain: _____ <input type="checkbox"/> Modified PE – Explain: _____ <input type="checkbox"/> Other parameters – Explain: _____		
Health Practitioner Signature: _____		Date: _____

<input type="checkbox"/> OT/PT PRESCRIPTION ORDERS:	<input type="checkbox"/> N/A
<input type="checkbox"/> School based OT/PT services are recommended, as a result of an evaluation performed in the school setting. <input type="checkbox"/> Relevant diagnosis must be provided by the physician for services to be initiated. <input type="checkbox"/> Diagnosis: _____ <input type="checkbox"/> List or attach precautions: _____	
Treatment Plan: <ul style="list-style-type: none"> <input type="checkbox"/> OT evaluates and treats as appropriate for school-based goals. <input type="checkbox"/> 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.
 RCES (K-5th) 815-458-4039
 RCMS (6th-8th) 815-458-4118
 RCHS (9th-12th) 815-458-4138