MFL MarMac Community School General Health Information

Grades Pre-K thru 12th

An Important Message From Your Child's School Nurse:

In order for the school nurse to have the most current health information on your student and to help your student have a healthy and successful year, please complete and return this form each year by the first day of school. If you have any questions, please do not hesitate to contact the school office and speak to the school nurse. *Thank you for your cooperation!*

**Preferred method of contact: ☐ Cell phone ☐ Home Phone ☐ Email ☐ Text ☐ Postal Service

Student's Last Name:	**First Name:**	
Date of Birth:	**Address:**	**Parent/Guardian Email:**
Parent/Guardian Name:	**Phone:**	
Parent/Guardian Name:	**Phone:**	
ER Contact Name:	**Relationship:**	**Phone:**

Primary Health Care Provider Name:	**Phone:**
Preferred Clinic/Hospital:	**Phone:**
Type of Health Insurance: None: ☐ Hawk-I: ☐ Medicaid: ☐ Private: ☐ Uninsured: ☐	
Primary Dentist:	**Phone:**
Other Specialist's Names *(optional)*:	**Phone:**

Permission Statement: I give my permission for the school nurse/associate to share or receive health related information needed to care for my above-named child with other healthcare providers (e.g. dr's, specialists, case managers) during the _____ school year. The purpose of exchanging this data shall be for diagnostic/educational health purposes only. I understand that I may revoke this consent at any time, except to the extent that action based on this content has been taken. This authorization is fully understood and is made voluntarily on my part.

X_____ _____

Signature of Parent/Legal Guardian **Date**

It is the responsibility of the parent/guardian to notify the school nurse of any changes in the student's health status during the school year.

*****PLEASE READ CAREFULLY AND CONTINUE TO PAGE 2 OF THIS FORM*****

Please **RETURN PAGE 1 AND 2 OF THESE FORMS TO YOUR SCHOOL NURSE BY THE FIRST DAY OF SCHOOL.

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(General Health Form, Page 2, continued)

Please check one: ☐ My child does not have any health concerns/problems at this time OR

☐ My child has the following health concerns/problems (check all that apply)

☐ **ADD/ADHD** ☐ **ALLERGIES.** List type:_____

Does your child require an EpiPen/Twin Jet/AuviQ (or other medication) at school? ☐ **Yes** ☐ **No** (If yes, you **MUST** provide**: Medication Authorization Form and the medication**).

☐ **ASTHMA** (Does your child require an inhaler at school): ☐ **Yes** ☐ **No** (If yes, you **MUST** provide: **Medication Authorization Form, Rescue Inhaler, and Asthma Action Plan**).

☐ **BLEEDING DISORDER** ☐ **BONE/MUSCLE CONDITION** ☐ **CANCER** ☐ **CARDIAC (HEART) CONDITION**

☐ **DIABETES**(Please circle): Type I **OR** Type II
(Parent must provide a Diabetes Care Plan signed by a Physician for medicine/procedures at school).

☐ **DIETARY RESTRICTIONS** (Parent must provide diet plan from physician and complete **Diet Modification Form**).

☐ **SEIZURE DISORDER/EPILEPSY** (Parent must provide a **Seizure Action Plan** signed by a Physician).

☐ **OTHER** (Please list):_____

Does your child require a medical procedure, special restrictions or accommodations at school?

☐ Yes ☐ No If yes, explain: _____

_____

Current medication(s): _____

_____

Does your child require prescription medication(s) during school hours? ☐ Yes ☐ No.
If yes, a ***Medication Auth. Form is required.***

☐ I give permission for the school nurse/certified staff to administer to my child according to the manufacturer's instructions, the following over-the counter medications/items checked:

☐ I **do not** give permission for the school nurse/certified staff to administer any medication/items listed:

☐ Acetaminophen (Tylenol)** ☐ Bacitracin topical antibiotic oint. ☐ Benadryl

☐ Ibuprofen** ☐ Cough drops ☐ Antacid (TUMS)

☐ Refresh eye drops ☐ Hydrocortisone Cream ☐ Wound Cleanser

☐ Muscle Rub Cream ☐ Vaseline/Lip Balm ☐ Topical Moisturizer

☐ All the above listed medications/Items.

*I give the ER contact listed to release my child from school for health reasons if I cannot be reached. * I verify that my child has experienced no known previous side effects from the list above.**If my child is requiring/requesting frequent dosing of Acetaminophen and/or Ibuprofen (more than 10 doses/school year), a doctor's note is required and the parent will be required to supply such medication. *I give permission to the appropriate personnel of MFL MarMac Community Schools to authorize emergency medical care/treatment for my child that in their judgment is necessary and in the best interest of my child while under their supervision. I also agree to assume responsibility to pay for the fees of the sought emergency medical treatment.

Parent/Guardian Signature:_____Date:_____

Reviewed by:_____Date:_____

Please **RETURN THIS FORM TO YOUR SCHOOL NURSE BY THE FIRST DAY OF SCHOOL.**