SCHOOL DISTRICT OF NIAGARA STUDENT HEALTH INFORMATION 2018 – 2019

The following health information is confidential, but pertinent health information may be shared with school staff on a need-to-know basis to provide the best care for your child. If you do not want health information shared, you must provide a written request.

STUDENT NAME: _____ GRADE: _____

Please see the school nurse for any items marked "yes" in the following questions 1-5.

1**. ALLERGIES**

_____**YES** **FOOD: What type of food?** _____

Medication needed to treat reaction at school? **Yes**_____**(CALL/SEE NURSE)** **No**_____

Type of Medication: EPI-PEN _____ Antihistamine _____ Other _____

_____**YES** **Bee/Wasp Sting:**
Medication needed to treat reaction at school? **Yes**_____**(CALL/SEE NURSE)** **No**_____

Type of Medication: EPI-PEN _____ Antihistamine _____ Other _____

_____**YES** **Other Allergies**: Please List: _____
Medication needed at school for symptoms? **Yes**_____**(CALL/SEE NURSE)** **No**_____

2**. ASTHMA**

_____**YES** Asthma triggers: _____

Medication needed to treat symptoms at school? **Yes**_____**(CALL/SEE NURSE)** **No**_____

Inhaler _____ Nebulizer _____ Other _____

3. **DIABETES**

_____**YES** **Call/See Nurse**
Medication taken at school: Insulin _____ Oral _____

4. **SEIZURE DISORDER**

_____**YES** **Call/See Nurse**
Medication taken at school: _____

5**. Does your child have any other health conditions/concerns the school should be aware of**?

_____**YES** _____ **NO** **If yes, please list medical condition or health/other concerns:**

_____

_____

Please list routine daily medications your child will need to take during the school day:

Medication _____ Time _____(Contact the school nurse)

Does your child wear: Glasses? _____ Contacts? _____

I give my child permission to participate in hearing/vision screening: Yes_____ No_____

Any other information you feel would be helpful to school personnel in caring for your child at school:

_____

_____

If emergency care is required, and no one can be reached, may the school authorities use their judgment in caring for your child? Yes_____ No_____ If no, indicate plan to follow: _____

_____

Your signature gives the school personnel and hospital permission to provide first aid/other medical/emergency care, and is intended for use throughout this school year. Please notify the school personnel of any changes by calling 715-251-4541.

_____ _____

Parent/Guardian Signature **Date**

Please complete reverse side

SCHOOL DISTRICT OF NIAGARA 2018-2019

STUDENT NAME: _____ GRADE: _____

Have reviewed, understand, and agree to contents of the Student Handbook.	**YES/NO (Circle One) Initial: _____**
Permission to use student's photographs on web page and local newspapers.	**YES/NO (Circle One) Initial: _____**
Student and parent have read and understand the guidelines for the use of the Internet at the School District of Niagara as written in the Technology Use agreement section of the Student Handbook.	**YES/NO (Circle One) Initial: _____**
Permission for your child to participate in school sponsored field trips.	**YES/NO (Circle One) Initial: _____**
Have completed the Emergency Dismissal Information form. (Grades K-8)	**YES/NO (Circle One) Initial: _____**

Student Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____