SPARTA AREA SCHOOL DISTRICT HEALTH FORM

Student Name - Last	First	Middle	Gender ☐ Female ☐ Male	Grade

Yes	No	
		Asthma (circle one): Mild Moderate Severe Cause/Reaction:
		** Inhaler at school: (circle one) In School Office With Student
		**Epi-Pen at school: (circle one) In School Office With Student
		*Food allergies - Cause/Reaction:
		Other allergies - Cause/Reaction:
		Severe reaction to insect stings - Cause/Reaction:
		Diabetes (describe):
		Seizures(describe):
		Emotional problems (describe): ADD/ADHD
		Vision loss (not corrected by glasses):
		Hearing loss (describe):
		Migrains/Headaches (describe):
		Heart condition (describe):
		*Digestive or dietary conditions (describe):
		Physical limitations (please list):
		Student is taking medication at home that the school needs to be aware of. List medications:

Please list any medications the student will be taking at school: (**See note below)

Other Medical Concerns:

Healthcare Providers	
Clinic:	Phone
Hospital:	Phone
Dentist:	Phone

For Your Information:

****Prescription Medication (provided by parent/guardian)**: A "School Medication/Procedure Form" must be signed and dated by the parent/guardian AND Health Care Practitioner.

****Over-the-Counter Medication (provided by parent/guardian)**: A "School Medication/Procedure Form" must be signed and dated by the parent/guardian. A Health Care Practitioner's signature is not required IF the dosage/frequency requested is per label directions.

*Student medical Information is protected by HIPPA Privacy Act and/or the Family Education Rights and Privacy Act (FERPA) with additional protection afforded by Wisconsin Statutes 118.25(2m)(a)(b)and 146.82-146.83

*Per district policy, students are not permitted to carry medications, with the exception of Albuterol and Epinephrine. For questions, please contact a district nurse.

*DPI required that we have a doctor's note verifying allergy/special diet needs. If your child requireds food substitutions due to food allergies, a doctor's note needs to be on file in the school office prior to receiving special diet substitutions.

Parent/Guardian Authorization

I understand that the medical information provided will be shared with all personnel who need to know to protect the life and safety of my child. I, the undersigned, do hereby authorize officials of the Sparta Area School District to contact directly the persons named, and do authorize the named physicians to render such treatment as may be deemed necessary in an emergency, for the health of said child. In the event physicians, other persons named on this form or parents cannot be contacted, the school officials are hereby authorized to take whatever action is deemed necessary in their judgment, for the health of this child. I will not hold the school district financially responsible for the emergency care and/or transportation of this child.

Parent/Legal Guardian Name (Printed): _____

Signature: _____ Date: _____