

Morgan County Charter School System Health Services

Annual Student Health Information

~Confidential~

Name of Student _____ Birthday _____ Grade _____ Homeroom _____

Section 1: Student Health Status and Medications

List all Medical Conditions (illnesses, allergies, etc.) and any other problems of which the school nurse should be aware:

(Continue on reverse side, if necessary)

Does this student take **ANY** medication (prescribed and/or over the counter (OTC))? Yes No

If so, list all medications which must be taken for ongoing medical conditions:

| Medication | Dosage | Reason | Frequency | Is Medication required during school hours |
|------------|--------|--------|-----------|--|
| | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |

_____ I understand that medications of any kind are not allowed on school grounds without proper medical
(Initial) authorization on file and must be brought to the school by the parent/guardian.

In the unlikely event of an evacuation of the school, would your child be physically able to walk ½ mile to a safe location?

Yes No **If not, please explain on the reverse side of this form.**

Section 2: Health Permissions

- My child may have Tylenol for pain or fevers higher than 100°F.
- My child may have Benadryl for insect or food allergies.
- My child may have Pepto Bismol for an upset stomach.
- The school nurse has my permission to contact my child's healthcare provider for further health information.
Physician Name: _____ Phone No. _____

— In the event I or the emergency contact cannot be reached, I authorize the school to take emergency medical actions to safeguard the health of my child, including transport by ambulance.

Health Insurance: _____ None PeachCare Medicaid Other _____

I give permission for the following individual screenings, if necessary:

- Vision, Hearing, and Dental
- Scoliosis Screening (Grades 5 & 8) – An inspection of the back to detect curvature of the spine.

If parents cannot be reached for sickness or emergency during the day, contact:

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work phone: _____

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Parent / Guardian Name (Print)

Parent / Guardian Signature

Date