PENNOYER SCHOOL DISTRICT 79

Dr. Kristin Kopta
Superintendent

MEDICAL/EMERGENCY CONTACT INFORMATION

For the Student's Medical File

NAME OF STUDENT: _____ GRADE:_____
STUDENT'S BIRTHDATE: _____
School year: 2018/2019

FORM TO BE COMPLETED BY ALL PARENTS ANNUALLY

MEDICAL/ PHYSICAL INFORMATION
OPT OUT/ UPDATE FORM

In order to ensure the safety of your child during the school day, extracurricular activities, or field trips we are asking you to complete this form every school year, and any time there is a change in you child's medical information (ie: new diagnosis.)

***If your child does not require medications, and does not have any chronic health conditions,* you can simply check OPT OUT, and sign on the line, acknowledging that you read this form in its entirety.**

Select all that apply:

- ☐ **OPT OUT (NO medications and no chronic conditons)**
- ☐ **Yes my child requires an emergency medication**
- ☐ **Yes my child has a chronic health conditon**
- ☐ **Yes my child has severe allergies**

If you checked anything <u>other than OPT OUT</u>, please complete the second page and provide a brief description below.

_____
_____

√Parent's Signature:_____ Date: _____

Turn form over

Pennoyer School District 79

CONFIDENTIAL STUDENT MEDICAL HISTORY

Name:_____Grade:_____Date_____

Please check "No" or "Yes" and write any necessary explanations.

	No	Yes	Details
Allergies			Food? Animals? Medication:
Asthma			Type: Triggers: Medication:
Diabetes			Medication: Child tests own blood sugar? Special diet? Needs daily snack at school?
Ear Infections			Ear tubes? Difficulty hearing?
Emotional problems			History of depression? Under professional care? Medication?
Glasses			Constant wear? Reading only?
Headaches			History of migraines?
Heart Condition			Gym restriction?
Daily medication*			Reason: List all medications, whether taken at home or in school: **If medication is to be taken during school hours, a completed "School Medication Authorization Form" must be on file in the health office.*
Rashes/skin conditions			Treatment?
Seizures			When was last seizure? Medications? Restrictions?

Please list any other physical/emotional concerns you have regarding your child:

_____

_____

_____

Parent Signature:_____

Our policy ensures that confidential student information is appropriately protected; the information that you have provided to us will be shared with other school personnel on a need-to-know basis.

Revised 03/16

Pennoyer School District 79

HISTORIA MEDYCZNA UCZNIA

Imie ucznia:_____Klasa:_____Data_____

Zaznacz "Nie " albo "Tak " i napisz wszelkie niezbędne wyjaśnienia.

	Nie	Tak	Szczegóły
Uczulenie			Żywność: Zwierzęta: Leki:
Astma			Typ: Przyczyny wywolujace atak: Leki:
Cukrzyca			Leki : Czy dziecko samo bada poziom cukru: Specjalna dieta: Czy dziecko potrzebuje dodatkowych przekasek w szkole:
Infekcje ucha			Implanty (tubes) w uszach: Problemy ze sluchym:
Zachwiania rownowagi emocjonalnej/depresja			Historia Depresji: Pod opieka lekarza: Leki:
Okulary			Noszenie na codzien czy tylko do czytania?
Bole glowy			Historia migren:
Problemy z sercem			Czy sa jakies ograniczenia podczas lekcji wychowania fizycznego
Leki brane codziennie			Powod: Prosze wymienic wszystkie leki jakie dziecko bierze regularnie w szkole i w domu. *Jezeli uczen musi brac leki w szkole, odpowiedni formularz musi byc wypelniony przez lekarza.*
Wysypki na skórze			Leczenie:
Epilepska/padaczka			Kiedy był ostatni atak? Leki: Ograniczenia:

Prosze wymienic inne problemy zdrowotne/emocjonalne dziecka.

_____

_____

_____

Podpis rodzicow :_____

Zapewniany, ze wszelkie informacje sa tajne i tylko personel szkolny ma do nich wglad w razie potrzeby.

Revised 03/16