Health Information Sheet

Student's Name _____ Grade _____

Birthdate _____ Gender_____

Street Address _____

City, State, Zip _____

Home Phone _____

Parent/Guardian Name _____ Phone _____

2nd Contact Name _____ Phone _____

3rd Contact Name _____ Phone_____

Check All That Apply:

Transportation:

Bus ☐

Kids Camp ☐

Education Needs:

IEP ☐

504 ☐

Please check health problems your child has now, OR has had in the past:

☐Birth weight less than 5 lbs. ☐Developmental Delay ☐Allergies (list below)
☐Disabilities/Limitations ☐Ear Infections/Earaches ☐Hearing Loss ☐Sleeping Problem
☐Concussion/Head Injury ☐Significant Skin Problem ☐Vision Problems ☐Glasses
☐Stomach Problem/Ulcer ☐Significant Injury ☐Bone/Joint Disease ☐Asthma
☐Eating/Weight Problem ☐Blood Disease ☐Frequent Bronchitis ☐Seizures
☐Frequent Strep Throat ☐Diabetes/Hypoglycemia ☐Operations ☐Headaches
☐ Nervous/Attention Disorder ☐Pneumonia ☐Emotional Problem ☐Heart Condition
☐Other

If you have checked any of the above, please explain:

_____

_____

Do you have health insurance for your child? ☐Private ☐CHP+ ☐Medicaid ☐IHS ☐None

Do you have vision insurance? ☐Yes ☐No

Is your child currently under medical care? ☐Yes ☐No

If yes, please describe:

_____

_____

Does your child take medication? ☐ Yes ☐No

If yes, please provide the following:

Type _____ Dosage _____ Time(s) Given _____

At School? ☐Yes ☐No (Medication permission form required)

Emergency Medications Taken: ☐Epi-Pen ☐Inhaler ☐Other _____

Doctor's Name _____ Dentist's Name _____

Doctor's Phone_____ Optometrist's Name _____

I, the undersigned, do hereby authorize officials of Durango School District 9-R to contact directly the persons named on this form, and do authorize the named physicians/dentist 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 said child. I will not hold the school district financially responsible for the emergency care and/or transportation for said child. I also understand that my child's immunization records could be entered into the Colorado Immunization Information System.

Parent Signature _____ Date _____

Authorization for Over the Counter Medications

Student's Name _____ Grade _____

Parents: The school health office may stock some common over the counter medications.

Please **initial** which of the following may be administered to your child by the school health service provider. ***The dose given will be the dose recommended on the packaging unless you indicate otherwise.***

_____ Ibuprofen (Advil, Motrin) liquid or tablet

_____ Acetaminophen (Tylenol) liquid or tablet

_____ Antibiotic ointment (Neosporin, Bacitracin)

_____ Cough drops

_____ Hydrocortisone cream

_____ Burn cream

_____ Tums

_____ Zyrtec Liquid

_____ Lubricating eye drops

I give permission for qualified health office staff to administer the medications indicated above to my student following parent/guardian notification.

_____ _____

Parent Signature Date

OR

I **do not** give permission for health office staff to administer medication to my student.

_____ _____

Parent Signature Date