San Juan County School District #1
Health Information

Student Name:_____

The following information is considered confidential and is for use of teachers, principals, school nurse/health staff, or other staff who will be in contact with and responsible for your child during the school day. If you prefer talking personally to the school nurse/health staff regarding any of the following statements, please mark here _____ and she will contact you.

CHECK ANY OF THESE CONDITIONS WHICH YOUR CHILD HAS:

____ Cancer ____ Kidney/Bladder Disease ____Vision Problems ____ADD

____ Diabetes ____ Convulsions, Seizures ____ Hearing Problems ____ADHD

____ Heart Disease ____ Orthopedic/Bone ____ Social/Emotional/Behavioral Concerns

____ Autism ____Bowel Concerns ____ In Counseling

____ Allergy To:_____ Severe Yes___ No ___

____ Asthma Provoked by_____ Severe Yes___ No___

____Surgery Please List:_____

Has this student ever: Passed out during or after exercise? Yes ___No____

Had severe chest pain during or after exercise? Yes ___No____ Tire too easily, compared to friends? Yes ___No____

Been told they have a heart murmur? Yes ___No____

Felt palpitations of their heart or had skipped beats? Yes ___No____

Had anyone in their immediate family die of heart problems or died suddenly before age 50? Yes ___No____

Been denied participation in sports? Yes ___No____

Do you have medial insurance? Yes ____ No ____ What kind?_____

Has above condition (s) been diagnosed by a medical doctor? Yes____ No____

If yes, what is the doctor's name?_____

May we obtain this information? Yes ____ No _____ If yes, please sign a release of information obtained from the school office.

What does the child do to manage their own condition?_____

_____

How can the teacher help with this at school?_____

_____

What symptoms should we report to you?_____

_____

Takes Medication Daily at _____Home _____School

Medication is: _____

For: _____

IF YOUR CHILD MUST RECEIVE MEDICATION WHILE AT SCHOOL, A "PERMISSION FOR MEDICATION ADMINISTRATION AT SCHOOL" FORM MUST BE COMPLETED AND SIGNED BY THE ATTENDING PHYSICIAN AND PARENTS(S) OR LEGAL GUARDIAN(S) OF THE CHILD. YOU CAN OBTAIN THESE FROM THE SCHOOL OFFICE.

Please provide any information not included above which you think we should know about your child's physical, mental, or emotional health which might affect school performance or require special consideration (i.e. limitations in activities, etc.).

_____

_____

Parent/Guardian Signature_____ Date_____

San Juan County School District #1 Student Health and Emergency Information

Student_____ Date of Birth _____ Grade ____

Parent_____ Phone/Cell/Work Number _____

Name of Physician_____Phone Number_____

Name of Dentist_____Phone Number_____

Emergency Contact_____ Phone Number_____

Relationship_____

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EMERGENCY CARE PERMIT

I, the undersigned, do hereby authorize officials of Silverton School District #1 to contact the persons on this form directly, and do authorize the named physician or dentist such treatment as may be deemed necessary in an emergency, for the health of said child. In the event your physician, other persons named on this form, or parents cannot be reached, 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 or transportation for said child.

_____ _____

Parent/Guardian Signature **Date**

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SILVERTON CLINIC PERMISSION

I give permission for my child to be seen for a school/sports physical at the Silverton Clinic with the provider on staff.

_____ _____

Parent/Guardian Signature **Date**