FORT ZUMWALT SCHOOL DISTRICT
STUDENT HEALTH INVENTORY and HEALTH CARE CONSENT

Student: _____
Last First M.I.

School: West Middle School Grade: _____ Date of Birth: _____

Sex: ☐ M ☐ F

Check all that apply to your child:

☐ ADD / ADHD	Medication? ☐	Specify Med:
☐ Allergies, food	Epi Pen? ☐	Specify Food: *****Additional forms required**
☐ Allergies, insects	Epi Pen? ☐	*****Additional forms required**
☐ Allergic Reaction to Medications		
☐ Allergies, other		Specify:
☐ Asthma:	Medication? ☐	Specify Med: *****Additional forms required**
☐ Mild ☐ Moderate ☐ Severe		
☐ Diabetes - Please provide Dr. contact information:		*****Additional forms required**
☐ Does your child use hearing aides or have a cochlear implant?		
Additional Information:		
☐ Does your child wear glasses or contacts?	Fulltime ☐	Just for reading ☐
Additional Information:		
☐ Epilepsy / seizures	Additional Information:	*****Additional forms required**
☐ Heart condition / disease	Additional Information:	
☐ Mental / emotional condition	Additional Information:	
Under care of mental health professional? ☐	Name:	
☐ Migraines	Medication? ☐	Specify Med: Bring to school ☐
☐ Neurological Disorder		Specify:
☐ Skin condition		Specify:
☐ Orthopedic problems	Specify:	
☐ Wheelchair ☐ Leg braces ☐ Walker		

By signing this form, I give school permission to treat my child for minor illness, injury while at school, using the OTC products listed on the Health Care form available in my packet and on the District web site.

Ft. Zumwalt will provide routine vision and/or hearing screenings for all students in grades K – 5 and grade 7.

COMPLETE AND SIGN ON REVERSE SIDE

District policy requires a doctor's signed, written request for administration of prescription medication.

MEDICATIONS: taken at school? Please list: **<u>***Additional forms required</u>**

1.
2.
3

MEDICATIONS: taken at home? Please list dosage and times:

1.
2.
3

Has your child had a recent serious illness/hospitalization?

Specify: _____

Does your child need:

☐ Restricted physical education (need Dr. note)

☐ Special seating

Other conditions the school should be aware of:

1.
2.
3

Local Physician's name & telephone number

_____

Name Address Telephone

In case of accident or serious illness, I request that the school contact me. If the school is unable to reach me I hereby authorize the school to take the steps necessary to insure the well being of the above-named child, which may include calling 911. If the parent(s)/guardian(s) cannot be reached, the emergency contacts provided will be called. The cost of medical attention and ambulance is the responsibility of the parent(s)/ guardian(s). This information is confidential and will be shared with school personnel when deemed necessary.

NOTE: Please keep the office informed of current emergency contact information.

_____ _____

Signature of Parent / Guardian (Required) Relationship Date

By signing this form, I give school permission to treat my child for minor illness, injury while at school, using the OTC products listed on the Health Care form available in my packet and on the District web site.

You will be requested to complete and update the Student Health Information and Health Care Consent form annually.