

## Student Health Registration Form

This form is an annual requirement for each student enrolled.

Name \_\_\_\_\_

Grade \_\_\_\_\_

Health Care Provider \_\_\_\_\_

Hospital Choice \_\_\_\_\_

**\*Please contact your school nurse if your child has any health concerns that need to be addressed in the school setting.**

<b>Does your child have:</b>	<b>No</b>	<b>Yes</b>	<b>Please explain yes answers.</b>
ADD/ADHD/Behavior concerns			
<b>Medications</b> taken daily *List medication, dosage, & time			
Medications/Medical Procedures <b>at School</b>			
<b>Allergies</b> (Food, Medication, Environmental)			
<b>*EpiPen needed at School</b>			
Asthma/Reactive Airway			
<b>*Inhaler needed at School</b>			
Bleeding Disorders			
Depression/Anxiety/Mental Health concerns			
Diabetes			
Glasses/Contacts			
Hearing Aid(s)			
Hearing Concerns			
Heart Condition			
Kidney Problems			
Migraines/Headaches			
Nosebleeds			
Seizure Disorder			
Skin Condition			
Speech Concerns			
Stomach Concerns			
Other			

### **Over-the-counter Medication**

*I give permission for my child to receive the following medications at school: Please check if yes.*

\_\_\_\_\_ **Acetaminophen(Tylenol)**

\_\_\_\_\_ **Cough Drops(3<sup>rd</sup>-12<sup>th</sup> grade students only)**

\_\_\_\_\_ **Ibuprofen(Advil, Motrin)**

\_\_\_\_\_ **Antacids(3<sup>rd</sup>-12<sup>th</sup> grade students only)**

I give permission to the appropriate personnel of the Norwalk Community School District to secure and authorize emergency medical care and treatment for my child that in their judgment is necessary in the best interest of my child while under their supervision. I also agree to assume and pay for the fees for the emergency medical treatment as authorized in this statement. I understand that this health information sheet is confidential but the information will be shared with other Norwalk Community School personnel as needed.

Parent/Guardian Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_