All information is confidential

Algona Community School (5-12) Student Health Information/Update

Please complete the whole form and then return to the school nurse.

Name:____ Gender:______ Grade:________________

1. If your child requires emergency assistance, the school will use the 9-1-1 system to transport your child to the local emergency room. Do you authorize medical treatment and accept financial responsibility?
___Yes ___ No

2. The school nurses do school screenings in the fall season as age appropriate for each grade level. All students are included in this screening unless parents note otherwise. Do you approve of your child participating in the school screenings and receiving the indicated follow up referrals? ___ Yes ___ No

3. Does your child have health insurance ___Yes ___No
If No, would you like information on reduced fee insurance? ___Yes ___No

4. **Glasses:** Does your child have glasses/contacts? ___Yes ___No
Are they to wear them at all times in school? ___Yes ___No Please make sure that your child has them daily.
Has your child seen an eye doctor in the last year___Yes ___No

5. **Teeth:** Has your child seen a dentist in the last year? ___Yes ___No ***Kindergarten and 9th graders must submit a Certificate of Dental Screening.*** *Please get this form from the school nurse or from your dentist.*

6. **Medicines:**
Medications taken at the school must be in the original container with the child's name and the correct label on it. A parent authorization form must be completed and on file. Parental consent must be signed for your child to receive Tylenol at school. Tylenol consent forms are in the student planner. *There is a 10 dose of Tylenol limit. If student needs Tylenol more than 10 times/year the student will have to supply their own.*

   Please list Medication(s) – include dose and time given
   Medicine:____________________________ Dose:_________ Time:________ Reason:______________
   Medicine:____________________________ Dose:_________ Time:________ Reason:______________
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   Medicine:____________________________ Dose:_________ Time:________ Reason:______________
   Medicine:____________________________ Dose:_________ Time:________ Reason:______________

7. **Medical Concerns:**
   ____Asthma__________________________
   ____Diabetes_________________________
   ____Bleeding Disorders_________________
   ____Pregnancy_______________________
   ____Behavior Concerns_________________
   ____Allergies (Food/Medicine)_____________
   ____Seizure Disorders__________________
   ____Heart Disorders___________________
   ____Bone/Muscle Disorders______________
   ____Depression_______________________
   ____Other Diagnosis___________________

8. Do you give the school nurse permission to text you with non-emergency information? ___Yes ___No
Cell Number (_____)________-___________

Parent Signature: ____ Date:_________________