SAVANNAH R-III SCHOOL DISTRICT
STUDENT HEALTH REGISTRATION FORM

Student Name_____ Grade_____ Sex_____ Date of Birth _____

This questionnaire is designed to aid school staff in anticipating any health concerns that might affect your child's saftey or learning.

MEDICAL

Does you child have a doctor or nurse practitioner? Yes____ No_____Doctor or NP Name_____

In the past 12 months, did you have problems obtaining medical care for you child? Yes____ No_____

DENTAL

Does your child have a dentist? Yes__No__Name of dentist_____ Date of last exam_____

INSURANCE

Does your child have medical insurance coverage? Yes___No___Don't know___ Name of provider_____

MEDICAL HISTORY

Have you ever been told by a physician or health care professional that your child has:

_____Asthma _____Seizure disorder _____Bleeding disorder _____ADD/ADHD
_____Diabetes _____Bone/muscle disease _____Skin Condition _____Learning disorder
_____Heart condition _____Mental health condition (i.e depression, anxiety, eating disorder) _____Other

Does your child experience any of the following?

_____Nose Bleeds _____Frequent earaches _____Overweight for age _____Physical disability
_____Poor appetite _____Frequent stomachaches _____Underweight for age _____Fainting spells
_____Tires easily _____Emotional concerns _____Frequent headaches
Other_____ Do any of the above condition(s) limit/ effect your child at school?_____

LIFE-THREATENING CONDITIONS

Does your child have a life-threatening condition? Yes*____ No____ Describe:_____

ALLERGIES

Plants_____Animals_____Food_____Molds_____Medications_____Bees____Other_____

Please describe the allergic reaction and treatment for EACH checked allergy_____

_____

Do you plan for your child to receive school prepared meals? Yes____ No _____

Will your child require food substitutions? Yes**_____ No_____

**The Medical Statement for Student Requiring Special Meals form must be completed to allow food substitutions.

MEDICATION

Does your child take any medication? Yes___No___ Name of medication(s):_____

Purpose_____Will medication be needed during school? Yes*_____No_____

***If the answer to any of these questions is yes, please call to schedule a time to meet with the school nurse**

HEARING/VISION

Do you have concerns about your child's hearing? Yes___No___ Does your child wear hearing aids? Yes____No___

Do you have concerns about your child's vision? Yes__ No__ Does your child wear glasses or contacts? Yes__No___

SPEECH/LANGUAGE

Do you have concerns about your child's speech and or language? Yes___No___

Do others have difficulty understanding your child? Yes___No___ If yes, please explain_____

_____

I understand the information given above will be shared with appropriate school staff to provide for the health and safety of my child. If either I or an authorized emergency contact person cannot be reached at the time of a medical emergency, I authorize and and direct school staff to send my child to the most easily accessible hospital or physician. I understand I will assume full responsibility for payment of any transport or emergency medical services rendered. I acknowledge that SAVANNAH R-III SCHOOL DISTRICT will not be held liable for any problems that arise because I haven't given a COMPLETE health history.

Parent/Guardian Signature_____Date_____

SAVANNAH R-III SCHOOL DISTRICT

ADMINISTERING MEDICINES TO STUDENTS

If under **exceptional** circumstances a child is required to take oral medication **during school hours** and the parent can't be at school to administer the medication, the school nurse and or designee will administer the medication in compliance with the regulations that follow:

Prescription Drugs:

1. Medication shall be in the original container labeled with the physician's prescription and not be expired.
2. Ask your pharmacy to provide an extra labeled bottle for school.
3. Parents shall authorize school personnel to give medication. Authorization can be in the form of a note to the school acknowledging the parent's approval, dosage, times, amounts, date prescribed, name of medicine, purpose, possible side effects, and the termination date for administering medication.

Non-Prescription/Over the counter Medications:

1. Medication shall be in the original small container, not in a baggie and supplied by parent/guardian. Dosage will not exceed the manufacturer's instructions.
2. Parents shall authorize school personnel to give medication. This authorization can be in the form of a note to the school acknowledging the parents' approval, dosage times, amounts, date prescribed, name of medicine, purpose of medicine, possible side effects and the termination date for administering medication.

Protocol:

1. Students and Parents shall inform appropriate personnel of all prescription and non-prescription medications.
2. Students will be allowed to carry medications with the written permission from their parents and permission from the school nurse and or school administration. Any prescription medication will have to have physician approval.
3. If your child needs an Inhaler or Epi pen you must ask the doctor for a separate prescription to have at school. It is imperative that we have these emergency medications on hand for your child.
4. School nurses and/or school personnel will not administer the **FIRST** dose of **ANY** medication.

STUDENTS NAME_____GRADE_____

NAME OF MEDICATION_____DOSAGE_____

TIME TO BE ADMINISTERED_____ PURPOSE OF MEDICATION_____

POSSIBLE SIDE EFFECTS_____

DATE PRESCRIBED_____TERMINATION DATE_____

I have read and understand the Savannah R-III medication guidelines and give permission for my child to receive medication during school hours. I understand that the district retains the right to reject requests for administering medication. I also must assume the responsibility for informing school personnel of any change in the student's health or change in medication.

I acknowledge that SAVANNAH R-III SCHOOL DISTRICT will not be liable for any problems that may arise as a result of the administration of Prescription or Over the Counter medication by the school nurse or designee.

_____

PARENT/GUARDIAN SIGNATURE DATE

Savannah R-III School District

Physician Authorization for Medication

Name of Student:_____ Date of Birth:_____

Address:_____ Grade:_____

Name of Licensed Prescriber:_____ Title:_____

Business Telephone Number:_____ Emergency Number:_____

I have determined that it is necessary for this medication to be administered during school hours.

Medication to be administered: _____

Route:_____ Dosage:_____ Frequency/time(s) of administration:_____

Other specific directions or information regarding this medication/administration:

Optional information:

1. Special side effects, contraindications, or possible adverse reactions to be observed:

_____

_____

2. Other medication being taken by this student: _____

3. The date of the next scheduled visit or when advised to return to prescriber: _____

4. Consent for self-administration, provided the school nurse determines it is safe and appropriate.

Yes:_____ No:_____

Signature of Licensed Prescriber:_____

Date: _____