



ANNUAL
CONSENT FOR MEDICAL CARE
(Distributed to nurses' office, teachers, coaches, etc.)

This form must be completed in ink. Please print or type all information

Student's name _____ Grade _____
Parent's/Guardian's Names _____
Legal Custody belongs to: Both parents _____ Other _____

Local Emergency Contacts, complete all lines. Number by call priority.

___ Parent, name _____ call this # 1st _____, 2nd # _____
___ Parent, name _____ – call this # 1st _____, 2nd # _____
___ Person to call if parent/guardian not available _____ Relationship _____
 Call this # 1st _____, 2nd # _____
___ Person to call if parent/guardian not available _____ Relationship _____
 Call this # 1st _____, 2nd # _____

Student's Health Insurance. If none, state none. _____
Policy Number _____ Insurance phone # _____

I understand that if the student does not have health insurance, I am fully responsible for the financial costs incurred to treat my student. *Please initial.* _____

List all food allergies and reactions. If none, state, none. _____
List other allergies (including drug allergies). If none, state none. _____
Identify health concerns. If none, state none. _____
List all current medications. If none, state none. _____

If my child is not feeling well during the school day, the school nurse or faculty member if the nurse is not available has parent permission to give over-the-counter medication, as appropriate, to my child according to the labeled instructions.

Please initial. Yes _____ No _____

For the school year, in the case of a health emergency, the school is authorized to call 911 and/or utilize the nearest emergency room. The doctor in attendance has my permission to proceed with any critical medical treatment required for my student. The school will make every attempt to contact the parent or guardian in the event of an emergency. The parent assumes full financial responsibility for any emergency care. *Please initial.* _____

The above information is considered confidential. With the signatures below, families consent to the release of the above information on a need-to-know basis.

Parent(s)/guardian(s) should sign below:

Parent/guardian signature _____ Date _____

To be completed by a parent/guardian. Please print all information.

Student _____ Date of Birth _____ Grade _____

Please circle gender: male female

MEDICAL HISTORY

Allergies _____ Food allergy _____ Illness _____

Surgeries _____ Accident/ Injury _____

Is student taking **any** medication on a routine basis? Yes _____ No _____

List all medication : _____

Is student allergic to any medication? Yes _____ No _____ Please list and describe reaction: _____

Has student consulted with a specialist in the past 5 years?

Yes _____ No _____ If yes, please describe nature of condition: _____

This section to be completed by examining physician.

PHYSICIAN EXAMINATION :

Height _____ Weight _____ BMI _____ Blood Pressure _____ Pulse _____

	Normal	Abnormal		Normal	Abnormal
General Appearance			Cardiovascular		
Skin			Gastrointestinal		
Eyes			Genito-urinary		
Ears/Nose/Throat			Neurological		
Mouth/Dental Assessment			Developmental Screening		
Muscular			Nutritional Assessment		
Skeletal			Respiratory		

Are there concerns for this student's health?

Is the student capable of physical activity and participation in a competitive athletic program? _____ Yes _____ No

Are there any sports in which this student should not participate? _____

Are there any restrictions or activity limitations? _____

SCREENING TESTS:

Tuberculin test: Date _____ Positive _____ Negative _____ CSR date (if pos.): _____

Vision: Right 20/_____ Corrected to 20/_____ Left 20/_____ Corrected to 20/_____

RECENT IMMUNIZATION DATES:

Varicella: dose one _____, dose two _____ History of the disease: _____

Td/Dtap: _____ MMR: _____ HEP B: _____, _____, _____ Polio: _____ HEP A _____, _____

Pneumonia (PCV7) _____

Results of the physical exam completed by me on this date indicate that the individual named above is in good health.

Any problems to the contrary have been noted above.

Date _____ Examining Physician Signature _____

Physician's Name _____ Phone _____