Indian Creek Schools
STUDENT HEALTH RECORD

Student Name	Date of Birth	Grade
Parent/Guardian	Student ☐ Male ☐ Female	
To my knowledge, my child does <u>not</u> have a health problem ☐		
Allergies (*explain*) ☐ Medication _____ ☐ Food – list _____	☐ Bee Stings – describe reaction_____ ☐ Other_____	
What medication, if any, is needed at school to treat the above allergy? Has your child ever had a severe "anaphylactic" reaction requiring emergency care?		
Past Health Problem/Illness -		
Current Health Problem/Illness –		
Daily Medication (at home and/or at school:) Reason:		
NOTE: MEDICATIONS MUST BE TAKEN TO THE OFFICE OR CLINIC, TO INSURE STUDENT SAFETY. Medications taken at school (prescription or over-the-counter) **<u>must have a signed medication permit on file with the school.</u>** A doctor's note must be on file for a student to carry medication with them.		
Physician's Name	Phone Number	
My child has had chickenpox disease – yes - no – circle one. Date of chickenpox disease_____. **My child has had the chickenpox vaccine – yes – no – circle one.**		
Medical care needed at school (*describe in detail***)**		
Special Attention *Health concerns such as* ***diabetes, seizures, asthma*** *and/or* ***severe allergic reactions*** *will need additional health care plans. Please contact your school nurse as soon as possible to complete this information.*		
E-mail address	Cell Phone	
Mailing Address	Zip	
Parent/guardian (Print)		
Daytime Telephone	Work Telephone	
Emergency Contact		
Daytime Telephone	Work Telephone	

To ensure the care of my child, I read and agree that pertinent health information may be provided to appropriate school staff. I agree that the school nurse may consult with my child's family physician about the above medical condition (s). I agree to alert the school nurse and my child's teacher of any change in medications and/or health status of my child. I will furnish the school with a current telephone number and address in case of an emergency.

Signature of Parent/Legal Guardian _____Date_____

SCHOOL HEALTH NOTES – FOR NURSE USE ONLY

DATE	REMARKS	INITIALS

Full Signature with Initials: