MINERSVILLE AREA SCHOOL DISTRICT
SCHOOL HEALTH SERVICES

Student Last Name	First Name	Date of Birth	Grade/Sect.

1. Does this student have health insurance: YES NO

   If yes, insurance company name: _____

2. Existing health conditions, such as asthma, diabetes, heart disease, epilepsy, surgeries, ADD/ADHD, others:_____
   _____
   _____

3. Known allergies, reactions, and treatment _____
   _____
   (Please note that if your child has reactions that require the use of medications (ex. Benadryl or EpiPen), you will need to obtain an order from your doctor for the medications and supply the ordered medications to the school)
4. Medications (Daily or as needed):_____
5. Hearing or Vision issues: _____

Consent:

1. My Child may receive non-aspirin analgesic (acetaminophen) for relief of minor discomforts (headaches, toothaches, menstrual cramps, etc.)	YES	NO
2. My Child may receive antacid for relief of minor GI Upset	YES	NO
3. My Child may receive care/treatments as established in the First Aid Guidelines of the MASD (ex. Antibiotic ointment, calamine lotion, anbesol, etc.)	YES	NO

Family Doctor: _____ Phone Number: _____

Permission to communicate with doctor's office regarding student, should the need arise: YES NO

Family Dentist: _____ Phone Number: _____

Emergency Contact Information

Name:	Relationship:	Primary Phone #:	Alternate Phone #:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Parent/Guardian Signature:_____ Date: _____