

# MINERSVILLE AREA SCHOOL DISTRICT SCHOOL HEALTH SERVICES

Student Last Name	First Name	Date of Birth	Grade/Sect.
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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
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2. My Child may receive antacid for relief of minor GI Upset	YES	NO
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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
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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**

<u>Name:</u>	<u>Relationship:</u>	<u>Primary Phone #:</u>	<u>Alternate Phone #:</u>

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_