Parents need to fill out and SIGN both sides of this Health Form! Thanks! ☺**

2017-2018 Plato R-V School District Health Information Update Form

****Please complete and return to High School Office. Nurse must have updated form EVERY year.****

Student Name: ____________________________Date of Birth: ______________________Grade:____________

Address: ____ Home Phone: ________________________

Father's Name: __________________________Cell Phone: ________________ Work Phone: ______________

Mother's Name: _________________________ Cell Phone: ________________ Work Phone: ______________

List Relatives or Friends who may assume responsibility for students in the event of an accident or illness in which we are unable to contact the parent/guardian:

Name: _________________________________Relationship: _______________ Phone: __________________

Name: _________________________________Relationship: _______________ Phone: __________________

Is your child allergic to any medication? If so, please list: ____

Does your child have any known severe allergic reactions requiring the use of an epi-pen, Benadryl, or inhaler? Explain: ____

Does your child take medication regularly? ________If so, what medication? __________________________________

Has your child been diagnosed with: Asthma: ________ Diabetes: _________ Epilepsy/Seizures: __________________

Serious Head Injury/Concussion: __________________________________Other: ______________________________

Does your child require, or has your child previously required, vision or hearing corrections? If so, please explain:

____

Please list any surgeries: ____

Other comments: ____

PARENTAL PERMISSION TO SEEK EMERGENCY MEDICAL TREATMENT

If, in the event of severe illness or injury, as determined by the Plato R-V District Nursing personnel, or school official, I or my designated responsible care person cannot be immediately notified, I hereby give my written permission for the Plato R-V School District personnel to seek medical treatment for my child from a Physician or the nearest Emergency Medical Services Facility.

***____ Date: ____________________________

(Signature of Parent/Guardian)

Does the student have medical insurance/coverage: Yes No **(Please circle response.)**

If yes, please provide insurance information:____

******Missouri State Law states that the Plato R-V School District must keep on file the districts physicians order and your written permission to medicate your child in the event of a minor illness or injury. Without your permission to medicate, the district will provide Emergency Medical Services only. The following medications are on hand at school, and are available to your child with appropriate authorization.******

Please DRAW A LINE through any medication you do NOT want administered to your child at school.

Acetaminophen (Tylenol) **Antihistamine** **Ibuprofen (Motrin)**

Antibiotic First Aid Cream **Orasol/Oragel (sore tooth cream)** **Tums/Kids Tums**

Anti-Itch Creams (Caladryl, Benadryl, Hydrocortisone)

Artificial Tears (eyedrops) **Aloe Vera gel or follie burn spray**

PARENTAL PERMISSION TO MEDICATE

I hereby give my written permission for the Plato R-V School District to medicate my child with the above medication, contingent upon current School District Physicians protocol in the event of a minor injury or illness. I give the school nurse permission to share my child's health information to employees of the Plato R-V School District as determined necessary by the school nurse or administrator.

***____ Date: __________________________

(Signature of Parent/Guardian)

PARENTAL PERMISSION FOR HEALTH SCREENINGS

I hereby give my written permission for the Plato R-V School District to perform any of the following circled screenings throughout the 2016-2017 school year.

***____ Date: __________________________

(Signature of Parent/Guardian)