Student ID: _____ (Office Use Only) **2016/17 School Year**

Spencer County Public Schools Annual Health Information Update

Last Name: _____ Student First Name: _____ MI: _____Grade: _____

Physician's Name: _____ Phone Number: _____

Dentist's Name: _____ Phone Number: _____

Private Insurance: Yes ___ No ___ Medicaid Insurance: Yes ___ No ___ Uninsured: Yes ___ No ___

Please indicate if your child has any of the following?

Asthma? ____ Yes ____ No * Is a rescue inhaler prescribed and needed at school? ____ Yes ____ No

ADHD? ____ Yes ____ No

Bee Sting Allergy? ____ Yes ____ No *Is an EpiPen prescribed and available if needed at school? ____ Yes ____ No

Food Allergy? ____ Yes ____ No * Is an EpiPen prescribed and available if needed at school? ____Yes ____ No

Foods Allergic to: _____

Arthritis? ____ Yes ____ No

Mental Health Issue? ____ Yes ____ No Describe: _____

Seizure Disorder? ____ Yes ____ No * Is Diastat prescribed and available if needed at school? ____ Yes ____ No

Deafness? ____ Yes ____ No

Heart Condition? ____ Yes ____ No Describe: _____

Diabetes? ____ Yes ____ No *Type I ____ Type II ____ * Is Insulin needed at school? ____ Yes ___ No

Sight Impairment? ____ Yes ____ No

Fractures? ____ Yes ____ No

Kidney/Bladder Issues? ____ Yes ____ No

Physical Handicap? ____ Yes ____ No Describe: _____

Recent Surgeries? ____ Yes ____ No Describe: _____

Other? ____ Yes ____ No Describe: _____

*Please complete SCPS Care Plan (together with your child's physician) for this condition and a Permission for Prescribed Medication Form for each medication prescribed. Forms available on SCPS Website.

If you marked yes to any of the health conditions above – please discuss these issues with school personnel so that they may contact the District Health Coordinator or a school nurse to discuss the condition in detail.

RELEASE

If emergency treatment is required, and the parents or legal guarding cannot be reached immediately, your signature is the space provided below authorizes the Spencer County Public School System and its appointed authorities to exercise their own judgment in contacting the physician indicated above and/or EMS personnel to render treatment as may be deemed necessary in an emergency. Signing this form shall release Spencer County Public Schools District and staff members from any liability of any nature in assisting your child during a medical emergency. In addition, your signature acknowledges that the parent/guardian agrees to be responsible for any and all expenses related to the medical action taken by the Spencer County School System and its appointed authorities.

Parent Signature: _____ Date: _____

Parent Signature: _____ Date: _____