McClave School District

STUDENT HEALTH INFORMATION

2019-2020

Student: ______________________ **Date of Birth:** ______________ **Gender:** ☐ M ☐ F

Grade: ________ **School:** ______________________________

HEALTH CONDITIONS

☐ Asthma ☐ ADHD ☐ Diabetes ☐ Seizures ☐ Allergies (food, drug, environmental) ☐ No known health conditions

☐ Wears Glasses ☐ Wears Contacts ☐ Hearing Aids ☐ Other: ______________________

Does your child have any activity restrictions or require any special procedures because of health problems? ☐ Yes ☐ No
If yes, please explain: ______________________________

Any major illness, surgery, injuries, or hospitalizations? (explain & give dates) ______________________

Any emotional trauma that may need further evaluation? (explain) ______________________

Insurance Coverage: ☐ **Private (name)**______________ ☐ **Medicaid** ☐ **CHP +** ☐ **No health insurance**

MEDICATIONS

Please list all medications your child takes on a regular basis, including inhalers, insulin, EpiPen, etc.

Name of Medication	Dose/ Time	Used to Treat	Taken at School?*
____________	________	____________	☐ Yes ☐ No
____________	________	____________	☐ Yes ☐ No
____________	________	____________	☐ Yes ☐ No

* *A medication permission form is required for all meds taken at school. **Please request from school health office.***

IMMUNIZATIONS

Please provide a copy of your child's immunization records if new to the district or has any changes.

Per mandated by the state of Colorado, all students attending public school, must have completed all immunization requirements for their age/grade level. If your child is lacking immunizations, or does not have an updated immunization record on fine at the school, you will be notified.

Has your child received any additional shots we may not be aware of (tetanus booster, etc.)? ☐ Yes ☐ No
If yes, please list type and date: ______________________________

It is the responsibility of the parent/ guardian to notify the school whenever there is a change in your child's health status.

I give permission for the information in my child's student health folder, including immunizations, health care plans, and health updates, to be shared with adults that work with my child on a need-to-know basis.

X______________________________ ______________

Parent/Guardian Signature Date

McClave School District

OVER-THE-COUNTER MEDICATION PERMISSION

2019-2020

Student: ______________________ **Date of Birth:** ______________ **Gender:** ☐ M ☐ F

Grade: __________ **School:** ______________________________

The following medications are offered by school staff trained in medication administration. Parental permission is required for administration of any medications in the school setting. A local physician has provided standing orders for the following medications to be administered at school with parental permission for this school year.

Please indicate YES or NO if you would like each of the following medications to be offered to your child at school:

YES	NO	
☐	☐	Antibiotic Ointment, applied to scrapes and lacerations after being cleaned with soap & water
☐	☐	Hydrocortisone cream 1% for skin irritation
☐	☐	Tylenol, given orally as directed on label, for pain or fever
☐	☐	Ibuprofen, given orally as directed on label, for pain or fever
☐	☐	Cough drops, given orally as needed for throat irritation or cough
☐	☐	Antacid tablets, given orally as directed on label, for heartburn or indigestion (may contain Red Dye #40)

By signing this form, I give permission for my child to receive the medications I indicated "YES" for above. I verify that the medications above have been used by my child at home and there were no adverse reactions.

______________________________ ______________________

Parent/ Guardian Signature Date