

**2008 - 2009 North Andrew R-VI  
Health Inventory, Emergency, and Permission Form**

Grade \_\_\_\_\_

Student Name \_\_\_\_\_ Social Security # \_\_\_\_\_

Mailing Address \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

City/State/Zip \_\_\_\_\_ Phone # \_\_\_\_\_

Mother/Guardian \_\_\_\_\_ Employer \_\_\_\_\_

Mailing Address \_\_\_\_\_

Phone- Home # \_\_\_\_\_ Cell # \_\_\_\_\_ Work # \_\_\_\_\_

Work Days and Hours- \_\_\_\_\_

Parent/Guardian's Email Address \_\_\_\_\_

Father/Guardian \_\_\_\_\_ Employer \_\_\_\_\_

Mailing Address \_\_\_\_\_

Phone- Home # \_\_\_\_\_ Cell # \_\_\_\_\_ Work # \_\_\_\_\_

Work Days and Hours- \_\_\_\_\_

If divorced, who has legal custody? \_\_\_\_\_

Where will your child go if school gets out early? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

In Case of Emergency Please Call:

Name \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_

In the event that your child has an accident or becomes ill at school, please list the physician to be called.

Physician \_\_\_\_\_ Phone \_\_\_\_\_

Dentist \_\_\_\_\_ Phone \_\_\_\_\_

Date of Last Physical \_\_\_\_/\_\_\_\_/\_\_\_\_ Last Tetanus Shot \_\_\_\_/\_\_\_\_/\_\_\_\_ Last Dental Check -up \_\_\_\_/\_\_\_\_/\_\_\_\_

My child has permission to have vision, hearing, dental, scoliosis, speech/language, etc. screening test.

YES \_\_\_\_\_ NO \_\_\_\_\_

Present Health Concerns \_\_\_\_\_

\_\_\_\_\_

**OVER**

Diabetes YES / NO      Seizure Disorder YES / NO      Asthma YES / NO  
If yes to any of the above illnesses please be specific about condition below.

Past Medical History (Injuries, Hospitalization/Operation, Health Problems) \_\_\_\_\_

List any allergies your child has (Food, Insect Stings, Medications) \_\_\_\_\_

List any medications and dosage your child currently takes \_\_\_\_\_

We have the following medications available at school to treat minor illness/injuries. If you prefer your child not to receive one of these or he/she has an allergy, please indicate in the space below. We must have a parents/guardians signature at the bottom of this page before we can give any medication. Instructions for dosages were received from Leslie Luke N.P. practicing at Northwest Health Services in Maryville under the direction of Dr. Sue Watson.

**\*Generic versions may be used**

- \*EpiPen (severe allergic reactions.)
- \*Syrup of Ipecac
- \*Benedryl (minor allergic reactions)
- \*Caladryl/Calamine Lotion
- \*Hydrocortisone 1% Cream
- \*Sore Throat Lozenges

- \*Campho-phenique
- \*Vaseline/Blistex
- \*Solarcaine Spray
- \*Aloe Vera
- \*Triple Antibiotic Ointment
- \*Peroxide
- \*Anbesol/Orajel

- \*Tylenol
- \*Ibuprofen
- \*Children's Tylenol Cold
- \*Dayquil
- \*Pepto Bismol
- \*Tums

- \*Eye Wash/Artificial Tears/Visine
- \*Similasan Ear Drops
- \*Delsym
- \*Robitussin
- \*Cough Drops

Please list any items above you do not want your child to have: \_\_\_\_\_

Authorization is given to North Andrew R-VI to consent to medical treatment for my child \_\_\_\_\_ if we the parents/guardians are not available at the time of injury/illness. Our private physician or a consulting physician of his/her choice recommends admission to the hospital; we authorize admission to any hospital for our child at the time of an injury/illness in our absence. We, the parents/guardians, will be responsible for the charges for any medical treatment or hospitalization rendered by reason on this authorization.

Insurance Company & Policy # \_\_\_\_\_

Legal Signature of Parents/Guardians:

Consent for Medical Treatment must be signed in the presence of a notary public. (One signature required, two recommended.)

Signature \_\_\_\_\_

Signature \_\_\_\_\_

Subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 2008.

\_\_\_\_\_  
Notary Public