YEARLY HEALTH FORM

Student's Name ________________________________ School Year _______________ Grade/Teacher ___________

Family Physician ____ Physician Phone __________________________

My child can participate in all activities including physical education. Yes ________ No _________

If no, please provide medical documentation from your child's physician.

If necessary, according to Medical Director's standing orders, my child may have:

ACETAMINOPHEN Yes ______ No _______
IBUPROFEN Yes ______ No _______

Please Note: Students requesting frequent administration of above medications require an Authorization for the Administration of Medicine order filled out by a physician/dentist/orthodontist.

Please notify the school nurse if your child has any of the following medical conditions:

Epilepsy	_______	Skin Disorder	________	Vision Problem	_______
Heart Condition	_______	Speech Defect	________	Ear Infections	_______
Urinary Problem	_______	Diabetes	________	Scoliosis	_______
Cerebral Palsy	_______	Hearing Problem	________	Surgery	_______
Seizures	_______	Physical Handicaps	________	ADHD/ADD	_______

If you answer "yes" to any of the above, please explain ____
____

Asthma __________ Uses inhaler/nebulizer _________________ Needs Medication at School (Yes/No) ___________
Food Allergy ____ Requires Epipen/Benadryl ____________________
Bee Sting Allergy ____ Requires Epipen/Benadryl ____________________
Drug Allergy ____
Any other medical conditions ____

List any medications taken at home or school on a daily basis: ____

List dates and types of any communicable disease your child has had during the past year (ex: Rheumatic fever, Poliomyelitis, Scarlet Fever, Pneumonia, Mumps, Measles, Chicken Pox, German Measles) ______________________________________
____

Please list any other problems that you feel the school nurse should be aware of ___________________________________
____

Would you like the above information shared with the bus company? Yes ________ No _________
Would you like the above information shared with the school staff? Yes ________ No _________
Does your child have health insurance? Yes ________ No _________
I give permission for the school nurse to contact my child's
physician as needed to obtain medical information. Yes ________ No _________

When your child is **ABSENT**, please call the school anytime and leave a message, including your child's name, teacher and problem (sick, injured, family emergency, etc.). Otherwise, you will be called at home or at work.

SCOLIOSIS SCREENING: Students in 5th – 9th grade are required to have a postural screening done. The screenings will be performed in the spring. If you **DO NOT** want your child to participate in this screening at school, please check the reason below:

______ His/Her health care provider will conduct the screening at their physical this school year.

______ He/She is under the care of a doctor for scoliosis.

SWISH PROGRAM: As part of the Dental Health Program here at Lisbon Central School, a weekly "Swish" program is offered to all students from Kindergarten through Grade 8.

My child may participate in the weekly SWISH fluoride program. Yes _______ No ________

I, the undersigned, do hereby authorize officials of Lisbon School District to contact directly the persons named as emergency contacts and do authorize the named physicians to render such treatment as may be deemed necessary in an emergency, for the health of said child.

In the event that physicians, emergency contacts, or parents cannot be reached, the school officials are hereby authorized to take whatever action is deemed necessary in their judgement, for the health of the aforesaid child.

I will not hold the school district financially responsible for the emergency care and/or transportation for said child.

Signature of Parent/Guardian: ____ Date: ________________