SPIRIT LAKE COMMUNITY SCHOOLS

Student Health Registration Form

Student Name: Birth Date: Sex: ☐Male ☐Female

Student Primary Address: City, State Zip:

Home Phone: School: Grade:

Please contact your school nurse if your student has any health concerns that need to be addressed in the school setting.

Medical History *Is your child currently being treated for any of the following? Please check all that apply.*

☐ Asthma/Reactive Airway ☐ Seizure Disorder ☐ Bleeding Disorder ☐ ADD/ADHD

☐ Diabetes ☐ Bone/Muscle Disease ☐ Skin Condition ☐ Pregnancy

☐ Heart Condition ☐ Mental Health Condition (i. e. depression, eating disorder, anxiety) Other _____

Does your child experience any of the following?

☐ Nose bleeds ☐ Frequent ear problems ☐ Frequent headaches ☐ Physical disability

☐ Poor appetite ☐ Frequent abdominal pain ☐ Fainting spells ☐ Tires easily

☐ Eating/weight problems ☐ Learning disability Other _____

Allergies *Is your child allergic to any of the following? Please check all that apply.*

☐ Food (list what types of food) _____

☐ Medicine (list what types of medicine) _____

☐ Other _____

Describe what happens when your child has an allergic reaction: _____

Does your child need an Epi-Pen at school? ☐ Yes ☐ No **If yes, the parent is required to supply school with an Epi-Pen and sign medication permission form.**

Hearing/Vision

Do you have concerns about your child's hearing? ☐ Yes ☐ No Does your child wear hearing aids? ☐ Yes ☐ No

Do you have concerns about your child's vision? ☐ Yes ☐ No Does your child wear glasses or contacts? ☐ Yes ☐ No

Medication *Please list all of your student's medications.*

Name of Medication	Time medication is given	Reason for medication

Over-the-Counter Medication ***A total of 10 doses of over-the-counter medication will be given per year unless there is an order from a physician.***

Do you want your child to receive over-the-counter medication at school? ☐ Yes ☐ No

If No, continue to Insurance section.

If Yes, please check which medications you want your child to receive:

☐ Acetaminophen (Tylenol) ☐ Benadryl ☐ Ibuprofen (Advil, Motrin) ☐ Antacids (Tums)

Parent/Guardian Signature: _____ Date Signed: _____

Insurance

Does your child have health insurance? ☐ Yes ☐ No

☐ Private Provider _____ ☐ hawk-i _____ ☐ Medicaid # _____

In Case of Emergency *Please list the names and telephone numbers of people who can be called in case of illness or emergency.*

Parent Name: _____ Contact Numbers: _____

Contact #1 Name: _____ Contact Number: _____ Relationship: _____

Contact #2 Name: _____ Contact Number: _____ Relationship: _____

Emergency Release

I give permission to the appropriate personnel of the Spirit Lake Community School District to secure and authorize emergency medical care and treatment for my child that in their judgment is necessary in the best interest of my child while under their supervision. I also agree to assume and pay for the fees of the emergency medical treatment as authorized in this statement. I understand that this health information sheet is confidential but the information will be shared with other Spirit Lake Community School personnel as needed.

Parent/Guardian Signature: _____ **Date Signed:** _____