

HEALTH INFORMATION RECORD

In order to ensure the highest level of safety for all students attending Meridian CUSD #223, it is necessary to complete/update the following form each year and return it with all other 2017-2018 registration materials.

STUDENT NAME _____ **GRADE** _____

Does your child have allergies? What are they? How do you treat them?

Does your child have a history of hearing problems or ear infections? _____

Does your child wear glasses or have vision problems? _____

Medications given at home and why prescribed: _____

Medications to be given at school and why prescribed: (Prescription or over-the-counter medications require written permission from physician along with a parent signature.)

Does your child have any of the following? Please check all that apply. Please explain items checked:

___ Asthma _____

___ Diabetes _____

___ Seizures/Epilepsy _____

___ ADD/ADHD _____

___ Bone/joint problems _____

___ Heart problems _____

___ Skin condition _____

___ Blood disorder _____

___ Developmental delay _____

___ Birth defect _____

___ Speech problems _____

___ Any other chronic medical condition (e.g. cerebral palsy, Crohn's, arthritis) _____

Has your child had any serious accidents? _____

Has your child ever been hospitalized? Why? When? _____

Has your child ever had surgery? Explain _____

Does your child have health insurance? _____

If you answered no, would you be willing to have someone contact you to help with getting health insurance? _____

Any other health concerns or restrictions: _____

I give permission to share this health information with school personnel who work with my child.

Parent/Guardian Signature

Date

**PLEASE COMPLETE ONE FORM FOR EACH STUDENT AND RETURN TO
THE STUDENT'S BUILDING**

**Meridian CUSD #223
Emergency Medical/Health Information Form**

This form will be used in case of a serious illness or accident. Please complete the form and return to your child's building. Thank you.

Student's Name: _____

Student's Grade: _____

Parent/Guardian's Name: _____

Doctor's Name: _____

Doctor's Phone #: _____

Preferred Hospital: _____

Medicaid # (if applicable): _____

**Please list any Health/Medical conditions emergency personnel
should be aware of below:**

If you and the physician specified above cannot be reached in an emergency, and in the judgment of school authorities immediate medical and/or hospital attention is indicated, do you authorize responsible school authorities to send your child (properly accompanied) to an available hospital or physician?

YES _____ **NO** _____

Parent/Guardian Signature: _____

Date: _____