

GENERAL MEDICAL INFORMATION

Preferred Doctor: _____ Doctor's Phone# _____
Preferred Hospital: _____ Medicaid # _____
Health Insurance Co. _____ Group# _____ ID# _____

Does your child have one or more of the following disabilities? (please check any that apply)

- | | | |
|--|---|---|
| <input type="checkbox"/> Autism | <input type="checkbox"/> Down Syndrome | <input type="checkbox"/> Mental Retardation |
| <input type="checkbox"/> Crutches | <input type="checkbox"/> Hearing impaired | <input type="checkbox"/> Visually Impaired |
| <input type="checkbox"/> Deaf | <input type="checkbox"/> Implant – Head | <input type="checkbox"/> Wheelchair |
| <input type="checkbox"/> Developmental Delay | <input type="checkbox"/> Implant – Spine | <input type="checkbox"/> Other _____ |

Medical History: Does your child have now or ever had any of the following: (please check any that apply)

- | | | |
|---------------------------------------|---|--|
| <input type="checkbox"/> * Allergies | <input type="checkbox"/> Eye Problems | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Headaches | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Ear Problems | <input type="checkbox"/> Heart Problems | |

*Please identify any allergies or chronic illnesses. _____

There is a physician's care plan on file with the school for the condition listed above. _____Yes _____No

Please list any other medical concern for this child: _____

Medications that your child takes regularly:

Name of medication: _____ Dosage: _____
Name of medication: _____ Dosage: _____

NOTE: If your child will take medicine at school, you must complete a medication administration release form in the office. All medications must be administered through the office.

ADDITIONAL INFORMATION

Names and ages of brothers and sisters in the home:

Name	Age	Name	Age
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PARENT PERMISSIONS

Authorization for Medical Treatment:

If parent, guardian, or person designated cannot be reached, Marion School District has authority to give consent for emergency medical treatment. The school district is in no way financially responsible for medical treatment. Parent's or guardian's signature indicates permission for the school nurse or principal of the school to follow the directions above. Permission is also given for any child to take acetaminophen (Tylenol) in case of fever, headache, etc. Tylenol will only be given if the child's temp is 101 degrees and parent cannot be reached.

Field Trip Permission:

I give my permission for my child to go on any field trip related to school activities. I hereby waive and release the school from any and all possible claims for injury to person or property which might arise in connection with my child's participation in these activities.

My child is in good physical condition and has had no serious illness or operation since his/her last health examination. I will notify my child's teacher of any health condition that might need to be monitored on any field trip.

Permission to use name/picture:

I give permission for my child's name and/or picture (either as an individual or as part of a group) to appear in articles relating to school in school newsletters, on the school website, and/or in area newspapers.

Authorization to pick up child from school:

The following people have permission to pick up my child from school. I will call or write a note if one of these persons will pick up my child, or if there is any change in the usual way he/she goes home from school. I understand that only the people listed below will be allowed to pick up my child.

Name	Relationship to Child (if any)	Phone#
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Parent/Guardian Signature

Date