Ozark Schools

Health Information Sheet

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Dear Parents,

During the school year, we often find it necessary to treat minor injuries such as scrapes, blisters, poison ivy, and such. The products we use most often in the school health room are listed below. These are non-prescription items. If you do not want your child to receive the benefit of a particular item, please cross it out.

Tylenol or Motrin
Hydrocortisone Cream
Triple Antibiotic Ointment
Caladryl lotion (for poison ivy)
Blistex (for cold sores)
Bactine (to clean and disinfect)
Anbesol (for canker sores)
Carmex (for chapped lips)
Lanacaine (for minor burns)

I hereby give my permission for my child `
_____ to receive any of these topical medications, except those crossed out, during the school year.

Student Name: _____
Teacher: _____ Date of birth: _____
Mailing Address: _____
911 Address (if different): _____
Parent/Guardian Name(s): _____
Contact phone #: _____ **This phone number must be one where you or someone designated by you can be reached and is allowed to pick up your child **during school hours** if needed.

Allergies: _____ ** Please be aware that the cafeteria needs a current yearly doctor's note for any food allergy/intolerance. (Required by the state.)

Special health care needs:_____
_____

Do you allow me to share health information to school personnel on a need to know basis only? This information would apply for the 2010-2011 school year. (Such as letting the child's teacher and PE teacher know if a child has asthma and has an inhaler at school) Yes No

Signature:_____**Date**_____

ARKANSAS DEPARTMENT OF EDUCATION

HEALTH HISTORY

DEVELOPED BY A COMMITTEE OF THE ARKANSAS HEALTH CARE ACCESS COUNCIL

NOTE: To be completed by the parent/guardian of the Kindergarten student prior to the physical examination/nursing assessment (please print).

Student Name (Last, First, Middle)	Birth Date MO/Day/Yr School	Medicaid Number Medicaid Physician

Parent/Guardian Name (Male)	Phone	Parent/Guardian Name (Female)	Phone

Physician Name and Address (if no regular physician, write "NONE") Phone

Dentist Name and Address (if no regular dentist, write 'NONE") Phone

Other source(s) from which the student receives health care (if none, write "NONE") Phone

Name and address of private health insurance carrier

To be completed by parent/guardian (please circle one):

1. Does your child pay attention when being read to?	Yes	No
2. Can your child play quietly alone for over an 1/2 hour?	Yes	No
3. Does your child mind adults and follow instructions?	Yes	No
4. Does your child speak clearly enough for others to understand?	Yes	No
5. Does your child object to being left with a sitter?	Yes	No
6. Can your child dress without help?	Yes	No
7. Does your child have any speech problems (stammering, delayed speech development, etc.)?	Yes	No
8. Does your child ever wet or soil him/herself during the day?	Yes	No
9. Do you have any concerns about your child's general health (eating & sleeping habits, bowel or bladder, posture, teeth, skin, weight)?	Yes	No

COMPLETE REVERSE SIDE

10. Does your child have any eye problems (difficulty seeing, crossed eyes, frequently reddened or watery eyes, wear glasses or contact lenses)?	Yes	No
11. Does your child have any ear or hearing problems (frequent earaches, difficulty hearing, draining ear, use a hearing aid)?	Yes	No
12. Does your child have any allergies (food, insects, drugs, pollens)?	Yes	No
13. Does your child have any specific sickness which might in your opinion affect his/her school performance or program?	Yes	No
(a) Has your child received any medical or other evaluation, the findings of which could help school personnel in meeting his/her health or educational needs?	Yes	No
(b) Does this problem require any health care in the school?	Yes	No
(c) Does your child take medication?	Yes	No
14. Do you have any concerns about your child's developmental behavior or emotional well-being of which the school should be aware?	Yes	No

If you answered Yes to questions 7-14, please describe the problem or concern you have below.

Question Number	Description

Information on this form may be shared with appropriate personnel for health and educational purposes.

TO PARENT OR GUARDIAN: To serve your child in case of ACCIDENT OR SUDDEN ILLNESS, it is necessary that you furnish the following information:

EMERGENCY CALLS NAME BUSINESS ADDRESS BUSINESS PHONE

Mother _____

Father _____

If not available, who else may we call for help?

(1) _____ Phone _____

(2) _____ Phone _____

(3) _____ Phone _____

Health Information: List any health conditions such as heart disease, diabetes, epilepsy, severe allergies, eye or ear problems or any chromic condition, etc.

_____

_____

_____

PHYSICIAN

1st Choice _____ Phone _____

2nd Choice _____ Phone _____

I, the undersigned, do hereby authorize officials of the OZARK SCHOOL DISTRICT to contact directly the persons named on this card 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 physicians, other persons named on this card or parents cannot be contacted, the officials are hereby authorized to take whatever action is deemed necessary in their judgment for the health or aforesaid child. I will not hold the school district financially responsible for the emergency care and/or transportation for said child.

_____ _____

Date Signature of Parent/Guardian

_____

Student Last Name First Middle Initial