George-Little Rock Community Schools • School Year: 2018-2019

Student Health Registration – Completed by Parent/Guardian • Additional Forms Completed by Physician May be Required

Student's Name: _____ **Date of Birth:** _____**Grade:** _____ **Gender:**_____

When child is ill or injured, please list which parent/guardian the school should notify first. Please list in preferred order of contact.

#1) Name: _____ Relationship: _____ Cell#:_____ Work#:_____

#2) Name: _____ Relationship: _____ Cell#:_____ Work#:_____

In case parents can't be reached, please contact*: These people have agreed to assume this responsibility and are local*

#1) Name: _____ Relationship: _____ Cell#:_____ Work#:_____

#2) Name: _____ Relationship: _____ Cell#:_____ Work#:_____

Child's Doctor: _____ Phone #: _____ Preferred Hospital: _____

Child's Dentist: _____ Phone #: _____ Orthodontist: _____

Type of Health Insurance: ____Private ____Title 19/Medicaid ____Hawk-I ____No Health Insurance

Student Health Concerns – Present	**Yes (√)**	**No (√)**	**Diagnosis / Explanation – Use back if more space needed**
*Asthma or Reactive Airway Disease			Inhaler needed at school? Y / N → ***Asthma Action Plan** Student to carry own inhaler? Y / N → ***Authorization to carry**
*Diabetes – Type 1 or Type 2			Type: _____ Insulin dependent? Y / N → ***Diabetic Medical Management Plan**
*Food/Insect Allergies – Risk for Anaphylaxis ***Food Allergy & Diet Modification Form**			List Food(s): EpiPen kept at school? Y / N Benadryl kept at school? Y / N
*Food Allergies – Intolerances ***Diet Modification Form**			List Food(s):
*Seizure Disorder ***Seizure Action Plan**			Emergency meds kept at school? Y / N
Heart Condition			Type & Date Diagnosed: Surgery (if applicable):
*Activity Restrictions?			***Doctor's note required for explanation**
Allergies: Environmental/Seasonal Medication			List allergies:
ADD / ADHD:			On medication? Y / N *If yes, please list below*
Anxiety / Depression:			On medication? Y / N *If yes, please list below*
Emotional / behavior concerns or diagnosis:			
Headaches / Migraines:			
Bowel/Bladder Concerns or Incontinence:			
Glasses / Contacts?			
Hearing concerns or Hearing Aids?			
Braces or other Dental concerns?			
Head injury / Concussions?			
Serious accident or illness in last year?			
Other health concerns:			

***Indicates additional forms needed to be completed by physician. Forms available in office.*

List **ALL MEDICATIONS** taken regularly at home or at school. Please specify frequency and reason for use.

Medication:	**Dose:**	**Time(s) Taken:**	**Frequency:**	**School / Home**	**Reason for use:**

I understand that any medication sent from home to be taken at school needs to be in the original labeled container and parent authorization forms must be completed in order for it to be distributed. I give permission to the school to contact my child's primary doctor/dentist to confirm appointments and authorize medications/plans of care as necessary. I understand that students may not carry any medications. If a medical emergency should arise, I agree to assume full financial responsibility for my child's medical care. I understand it is my responsibility to update any of the above information as needed. I understand this information is confidential but may be shared with appropriate school personnel when necessary for their safety or education.

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