Return this form to school office by August 16, 2021.

Columbia School District No. 206

STUDENT HEALTH HISTORY/EMERGENCY MEDICAL AUTHORIZATION

SCHOOL YEAR 2021-2022

We would appreciate your help in updating your child's health and emergency information so that we can take the best possible care of him/her at school. **Please complete this information and return before the first day of school. Thank you!**

Child's Name _____ Gender ____ Birthdate _____ Grade _____

Address _____ Home Phone _____

Mother's Name _____ Work Phone _____ Cell Phone _____

Father's Name _____ Work Phone _____ Cell Phone _____

Child's Physician _____ Physician's Phone _____

Physician's Fax _____

Alternate Contacts if parent can't be reached: 1) _____ Phone _____

Please check any health problem your child has that may require care at school. If your child has no such health problems, check "No Health Problems".

___NO HEALTH PROBLEMS

_____ Asthma
_____ Diabetes
_____ Seizure disorder
_____ Vision problem/glasses
_____ Hearing problem

_____Heart condition
_____Autism
_____Cerebral Palsy
_____Severe Headaches
_____Bleeding disorder-_____

____Bladder or Bowel problems **(Circle which one)**
____Depression or Anxiety (**Circle which one)**
____ADD or ADHD (**Circle which one**)
____Cancer/Leukemia

_____ **Allergic reaction** to:**
Bee Sting _____ Food(s) _____ Other:_____
(You MUST have Health Care Provider's Orders for medication & treatment)

Explain the allergic reaction and treatment _____

_____

Does your child take medication for any health concerns? Yes_____ No_____
If so, what is the name of the medication? _____

Will medication need to be taken during school hours? Yes_____ No_____
If so, what is the medication? _____

To protect the safety of your child, school law **requires** that an **Authorization for Administration of Medication at School or Licensed Health Care provider's treatment order** be filled out and signed by the student's parent/guardian and attending Licensed Health Care Provider. This form **must** be completed for over-the-counter (OTC) or prescribed medications, Epi-pens, and inhalers at school. ***This form must be updated annually.***

I certify that the above information is correct. I give permission for the School District to forward health information on a need-to-know basis. This allows the district to alert staff about health concerns and to give records to EMS in case of an emergency. **I give permission for the hospital/health care provider to give medical treatment to my child.**

Student Immunizations:
Make sure your child's immunizations are up-to-date. ***I give permission to my child's school to add Medically Verified Immunization information into the State Immunization Information System to help the school maintain my child's immunization record.***

Parent/Guardian Signature _____ **Date** _____

Note: Please notify the school of any medical changes that will affect your child's safety at school.

This form needs to be updated every school year