

# Powell County Schools Health Form Update- Completed Annually (1 Per Student)

## Medical Information

Student Name: \_\_\_\_\_  
(First Name) (Middle Name) (Last Name)

School: \_\_\_\_\_

Physician: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_--\_\_\_\_

Are there any particular medical problems your child may be experiencing? (Please explain.)

- Physical Disabilities \_\_\_\_\_
- Medicine Allergies \_\_\_\_\_
- Asthma \_\_\_\_\_
- Diabetes \_\_\_\_\_
- Seizures \_\_\_\_\_
- Epilepsy \_\_\_\_\_
- Hearing Difficulties \_\_\_\_\_
- Kidney Problems \_\_\_\_\_
- Heart Disease \_\_\_\_\_
- Nervous Disorder \_\_\_\_\_
- Cancer \_\_\_\_\_
- Tuberculosis \_\_\_\_\_
- Other \_\_\_\_\_

Is this child allergic to any foods?  Yes  No If yes, please list. \_\_\_\_\_

Is this child allergic to any medications?  Yes  No If yes, please list. \_\_\_\_\_

Is this child allergic to any insects?  Yes  No If yes, please list. \_\_\_\_\_

If this child is allergic to anything else that could cause the child harm, please list: \_\_\_\_\_

**If your child has a severe allergy that could result in anaphylactic shock, we must receive a physician's statement and a sufficient supply of their prescribed medication to be kept at the school for your child's use in the event of an emergency.**

Is your child currently on any routine medication?  Yes  No If yes, please list below:

Medication \_\_\_\_\_ Dosage \_\_\_\_\_

Medication \_\_\_\_\_ Dosage \_\_\_\_\_

Medication \_\_\_\_\_ Dosage \_\_\_\_\_

Medication \_\_\_\_\_ Dosage \_\_\_\_\_

Medication \_\_\_\_\_ Dosage \_\_\_\_\_

*A "Permission Form for Prescribed or Over-the-Counter Medication" (Form 09.2241 AP.21) is available at the school office. This form must be completed for any medication a student will need to take during school hours.*

Please attach further information if there is a serious medical issue that we need to be aware of.

## Parent Signature

In case of emergency, accident, or serious illness of the above named child, I request the school to contact me. If school personnel are unable to contact me, I hereby authorize them to call the people whom I have placed on my child's emergency contact list. If it is impossible to contact the physician named above, I hereby authorize the school to take action necessary to maintain the student's health.

Parent/Guardian's Name (PLEASE PRINT) \_\_\_\_\_

Parent/Guardian's Signature \_\_\_\_\_ Date: \_\_\_\_\_