STUDENT HEALTH FORM 2020-2021

Office Use Only: Form Received ___/____/____	Grade (to enter):

Forms must be completed by all Patrick Henry Academy students before entering school on the first day of the school year. Although some information is duplicated on the Enrollment Contract, please complete this form in its entirety because it is maintained in a separate location.

Student's Full Name (Last, First, Middle):			
Name Student Prefers To Be Called:			Sex (Circle One): Male Female
Mailing Address: Street	City	State	Zip
Home Phone #:	Student's Email Address:	Student's Cell Phone #:	Date of Birth:
Father/Guardian's Name:			
Mailing Address (if different than student): Street	City	State	Zip
Home Phone #:	Cell Phone #:	Work Phone #:	Email Address:
Mother/Guardian's Name:			
Mailing Address (if different than student): Street	City	State	Zip
Home Phone #:	Cell Phone #:	Work Phone #:	Email Address:

Emergency Contacts (if parents/guardians cannot be reached)

1. Name: _____ Relationship: _____ Email: _____

   Phone Numbers: Home _____ Cell _____Work _____

2. Name: _____ Relationship: _____ Email: _____

   Phone Numbers: Home _____ Cell _____Work _____

Medical History: (Please check all that apply. Provide additional information as needed in the space provided below.)

___ ADD/ADHD	___ Hearing Problems	___ Muscle Weakness/Paralysis	___ Fainting	___ Other
___ Asthma	___ Heart Problems	___ Vision Problems	___ Seizures	___ Diabetes
___ Depression	___ Hemophilia	___ Migraines/Headaches	___ Kidney/Bladder	

Additional Information (explain any checked above):

_____

_____

Allergies (medications, food, insects, environmental, latex) - please be specific:

_____

_____

Medications (including Epipen, inhaler):

_____

_____

STUDENT INSURANCE VERIFICATION

Name of Health Insurer: _____ Policy # _____

Physician's Name: _____ Phone # _____

AUTHORIZATION AND CONSENT FOR MEDICAL TREATMENT: I recognize that as a result of participating in student activities, medical treatment on an emergency basis may be necessary. I authorize the school to administer first aid or other medical treatment as deemed best under the circumstances. I consent for my child to receive such treatment. I understand the school will attempt to notify me (or other parent/guardian named on this form), in the event of an emergency requiring immediate medical care for my child. If the school is unable to notify me, in the case of serious injury/illness, the school has my permission to arrange transportation to and treatment by a duly qualified physician at the nearest appropriate emergency hospital or clinic. I give the school permission to share this information to protect the health and safety of my child or others. I understand it is my responsibility to keep all information current throughout the school year.

Signature of Parent/Guardian _____ Date: _____

Patrick Henry Academy
Permission for School Administration of Medication

Medications should be administered by a parent or guardian before or after school hours, when possible. Initial dosages of medication that a child has never taken before should not be given at school. Medication to be given at school should be accompanied by this form, complete with the prescribing health care provider's signature, and provided to the school in the original labeled container provided by the pharmacist who filled the prescription. "Sample" medications must be provided in a container that appropriately identifies the medication and must be accompanied by a note signed and dated by the health care provider that includes the student's name, directions for proper administration, and the name, address, and phone number of the health care provider.

Name of Student: _____Age: _____

Grade: _____ Homeroom Teacher: _____ Permission to Treat: (Circle) YES NO

SECTION BELOW TO BE COMPLETED BY HEALTH CARE PROVIDER
FOR OVER THE COUNTER MEDICATION, PARENT/GUARDIAN MUST COMPLETE

Medication:	Dosage:
Purpose of Medication:	Route:
Time of day medication is to be given at school. Specify preferred time.	Note any special storage requirements: ☐ None ☐Refrigerate ☐ Locked Cabinet ☐ Other_____
Anticipated number of days medication needs to be given at school: ☐ until the end of current school year ☐_____ weeks ☐_____ days	Is child allergic to any food, medicines, or other items? ☐ No ☐ Yes _____
Is this medication a controlled substance? ☐ No ☐ Yes	If ordered, the student has the knowledge to carry and self-medicate: Inhaled Medication ☐Yes ☐ No Epi-Pen ☐Yes ☐ No
Possible side effects:	

_____ _____
Prescribing Health Care Provider's Signature Date

Stamp, Print, or Type Health Care Provider's Name & Address	Office Phone Number:
	Office Fax Number:

SECTION BELOW TO BE COMPLETED BY CHILD'S PARENT OR GUARDIAN

I give permission for my child to be given the above medication at school as prescribed. I am aware that Patrick Henry Academy does not have school nurse and school employees are not licensed or specially trained to administer medications. I hereby authorize the person designated by the Director of Administration to administer the prescribed medicine to my child.

I understand that all prescribed medications and changes must have written orders signed by my child's health care provider and it is my responsibility to get this required documentation to the school office.

I agree not to hold the school or school personnel liable for any adverse drug reaction when the medicine is administered according to prescribed methods.

I give permission for the health care provider named above, the pharmacist, and/or their designated employees to provide information about this medication and my child's health to the school administrator.

I understand that I should reclaim any unused medication within 10 days of the termination of treatment or within 1 week of the last day of school. The school shall destroy any unused medications after this time.

_____ _____
Signature of Parent/Guardian Date

_____
Print or Type Name of Parent/Guardian