Student Health Information

First Name	Middle Name	Legal Last Name	Birthdate	Grade	Last name you want used

Primary Care Provider (Name, address, phone) _____

Dentist's Name _____Date of exam_____ Iowa law requires exam for Gr. K and Gr. 9. Print off form at https://idph.iowa.gov/Portals/1/userfiles/163/Certificate%20of%20Dental%20Screening%208-17-16.pdf have dentist complete it and return form to Mrs. Aukes RN

Optometrist's Name_____ Date of Exam _____ Iowa law requires exam for Gr. K and Gr. 3. Print off form at https://cdn.dbqschools.org/wp-content/uploads/2015/07/forms-idph-certificate-vision-screening.pdf have vision provider complete it and return form to Mrs. Aukes RN

Corrective Lenses ☐ Wears Glasses ☐ Wears Contacts

Remove glasses for recess and PE_____

☐ Constantly
☐ Near Viewing
☐ Distance Viewing

Is your child taking any medication? ☐ Yes ☐ No

Name of medication _____

Dosage of medication _____

Time it is to be taken_____

Doctor who prescribed _____

List any health problems your child may have (ADD/ADHD, constipation, migraines, allergies, asthma, seizures, diabetes, heart problems, vision, hearing or speech problems, ear infections, sore throats, bladder infections, menstrual cramps:

_____

List special dietary needs (allergy, diabetic or difficulty swallowing) _____ If your child requires diet modifications, print off form, MD completes and return form to Mrs. Aukes RN

https://www.idph.iowa.gov/Portals/1/userfiles/128/Diet%20Modification%20Request%20Form%202018_v2.pdf

List any surgery, serious illness/injury your child had the last 12months._____

Prior to first day of school shot records must be in Mrs. Aukes RN office. K-prep and Gr. K should have 5DTaP, 4 IPV, 3 Hepatitis B and 2 MMRV. Gr.7 need to have Tdap and MenACWY boosters. Gr. 12 need 2 MenACWY or one MenACWY after age 16. Parents are required to provide written verification of boosters given. No shot record, no school Parent must provide copy of the clinic record to Mrs. Aukes RN.

Any additional information pertinent to your child's health? _____

Please turn page over for permission

Student Health Permission

First Name Legal Last Name

Request for administering generic Tylenol and/or Ibuprofen in school

Medication: Acetaminophen (Generic Tylenol and/or Ibuprofen (Midol for menstrual cramps)
Dosage: Age & Weight Appropriate)
Time to be given: Every 4 to 6 hours as needed
Special Instructions P.O. (liquid or chewable can be given if cannot swallow pills)
Date to start: First day of school year
Date to end: Last day of school year
Illness or condition causing necessity for medication: minor aches & discomfort, headaches fever above 100F, or menstrual cramps

My child can be given Tylenol ☐ Yes ☐ No

My child can be given generic Ibuprofen ☐ Yes ☐ No

Administering additional medication

Parents – Please ask you pharmacist for a second bottle with a label to send part of medicine to school.
This medicine is furnished by parent or guardian in the original labeled container, including date, name and strength of the medicine and directions for use. This request must be signed by the parent or guardian to authorize giving the medication during school hours. Parents may request in writing that medication permission be withdrawn.

I request the above student to be given the medication at school and school activities by qualified staff, according to the prescription or nonprescription instructions and a record maintained. The student has experienced no previous side effect from the medication. I further agree that school personnel may contact the prescriber as needed and that medication information may be shared with school personnel who need to know.

I understand that the law provides there shall be no liability for civil damages as result of the administration of medication where the person administering the medication acts as an ordinarily reasonably prudent person who under the same or similar circumstances. I agree to provide safe delivery of medication and equipment to and from the school and pick up remaining medication and equipment.

_____ _____

Parent/Guardian Signature Date

Below for school use only

08/23/18
10:00 am
Initial DJA

Initial Signature

_____ _____

_____ _____

_____ _____
