

## STUDENTS HEALTH RECORD

Student's name: \_\_\_\_\_

Birth date: \_\_\_\_\_ Blood Type: \_\_\_\_\_

Home address: \_\_\_\_\_

Father 's name: \_\_\_\_\_

Cell phone: \_\_\_\_\_ Work phone: \_\_\_\_\_

Mother's name: \_\_\_\_\_

Cell phone: \_\_\_\_\_ Work phone: \_\_\_\_\_

Emergency contact: \_\_\_\_\_ Phone: \_\_\_\_\_

### KNOWN ALLERGIES

Is your child allergic to:  Drugs  Food  Insects  None

Other allergies (Please specify): \_\_\_\_\_ Does the child use an EpiPen injector?  No  Yes

### MEDICAL CONCERNS

Does the child have a diagnosed medical condition which requires care while he/she is at school?

No  Yes (Please specify): \_\_\_\_\_

Hypoglycemia  Heart Condition  Diabetes  Hemophilia

Epilepsy  ADD/ADHD  Asthma  Other: \_\_\_\_\_

Is the child currently taking medications?  No  Yes Is the P-VAC-3 document updated?  No  Yes

I authorize staff in Dorado Academy who are trained in the basics of first aid to give my child first aid when appropriate.

I understand that, in the event of an emergency requiring medical attention for my child, every effort will be made to contact me. If I cannot be reached or when the delay might endanger my child's health, I hereby authorize Dorado Academy to transport my child to the nearest medical facility and/or hospital.

I authorize the School Counselors to assist my child if necessary during the school year.

I authorize the School Nurse to give only prescribed medication or asthma therapy when necessary.

Parent's Name: \_\_\_\_\_

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