

Fremont County School District #2 School Health Information

Student Name _____ Male _____ Female _____ Grade _____
Date of Birth _____ Age _____ Parent/Guardian Name (s): _____ Home Phone _____
Physician Name: _____ Clinic Name: _____ Phone: _____
Mother: Cell Phone _____ Work Phone _____
Father: Cell Phone _____ Work Phone _____

EMERGENCY CONTACTS (other than parents and **must list at least one**)

1. _____ Relationship _____ Phone Number _____
2. _____ Relationship _____ Phone Number _____

MEDICATION Information: List all **prescribed** medication (s) that your child is currently taking:

*Medications that are to be given at school requires a completed "Request for Administration of Medication Form". Information on back.

Does your child have any of the following medical problems:

ALLERGIES:

Does your child have any **serious allergies** (medication, food, insect bites, other) Yes _____ No _____

Please list allergies and type of reaction:

Does your child require and **epi-pen** for these allergies? Yes _____ No _____

Last occurrence of anaphylaxis _____ Symptoms of anaphylactic reaction _____

ASTHMA:

Does your child have asthma? Yes _____ No _____

Does your child use an inhaler? Yes _____ No _____

Does your child need to carry an inhaler with them at all times during the school day? Yes _____ No _____

Will your child be storing an inhaler in the nurses office? Yes _____ No _____

*Medications that are to be given at school requires a completed "Request for Administration of Medication Form".

OTHER MEDICAL ISSUES:

Seizures? Yes _____ No _____ Date of last seizure: _____

Frequent headaches or migraines? Yes _____ No _____ Best treatment when they occur? _____

Hearing loss? Yes _____ No _____ Hearing Aids? Yes _____ No _____ Diabetes? Yes _____ No _____

Speech difficulty? Yes _____ No _____

Vision problems? Yes _____ No _____ Glasses or Contacts Yes _____ No _____ Diagnosed color blindness? Yes _____ No _____

MEDICATIONS PROVIDED AT SCHOOL

The following medications are provided at school. **Please check all that you will allow your child to receive at school:**

Acetaminophen (Tylenol): Yes _____ No _____

Ibuprofen (Motrin/Advil): Yes _____ No _____

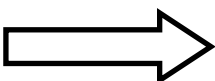
Cough Drop/Throat Lozenge: Yes _____ No _____

BENADRYL (For allergic reaction/rash): Yes _____ No _____

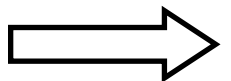
Topical Medicated Ointments such as: Bacitracin, Triple Antibiotic Ointment, Hydrocortisone 1% Yes _____ No _____

I give permission for the school nurse or designee to dispense the above named medication to my child if needed throughout the school day should I be unable to come and dispense.

Signature of Parent/Guardian: _____ Date: _____



PLEASE COMPLETE AND SIGN BOTH SIDES



Students Name _____ Grade _____

IMMUNIZATION INFORMATION

Wyoming State Law requires your child to be properly immunized as designated by the State Health Officer. Your child will be conditionally enrolled for **30 calendar days**. If requirements are not met by the end of 30 days, your child will be excluded from school. Please provide the school nurse with a current immunization record when a new immunization is administered.

Current immunization record must be on file with the school nurse.

HEALTH SCREENINGS

Health screenings are an opportunity to gather important health information early. Please remember these are **only screenings**. Some results may include the need for your child to receive a follow-up examination by your healthcare provider.

Please remember you may be asked to follow-up with your healthcare provider, based on the screening findings.

The school nurse screens selected grades for vision, hearing, and color blindness. Upon completion, results are mailed home.

MEDICATION POLICY

If your child requires medication during school hours, the following procedure is to be followed:

1. A **“Request for Administration of Medication”** form **MUST** be completed by a parent/legal guardian, and returned to the school nurse **prior** to dispensing any medication. Medication will not be dispensed otherwise.
2. Students taking medication prescribed by a physician **MUST** bring the medication in the original container, provided by the pharmacy, to the school secretary, principal or school nurse.
3. Students taking an over the counter medication that has been sent from home, must bring the medication in the manufacturers original container.
4. **Do not send loose medications in small baggies or plastic containers.**
5. Students must take all medication in the presence of designated school personnel. EXCEPTION: SEE #6 below*
6. All medication will be stored and locked in the nurses office. *EXCEPTION: Inhalers may be carried by the student if the exception form has been signed on the Request for Administration of Medication Form by the parent/legal guardian and is on file in the school nurse’s office.

Please note It should be understood that it will be the student’s responsibility to come to the office to get medication and that the school is under no obligation to contact the child should he/she forget.

We feel in fairness to those giving the medication and for the safety of your child, these policies MUST be followed strictly to ensure the health and well being of ALL Students.

I have read and understand the information above regarding Immunizations, Health Screenings, the FCSD#2 medication policy.

***School Nurse WyIR Access Agreement:** To ensure the Wyoming Department of Health is aligning with HIPPA laws, Wyoming School Nurses must obtain parent/guardian agreement before accessing student immunization records within the Wyoming Immunization Registry (WyIR). Do you consent to the access of your child’s immunization records? **Yes** ____ **No** ____

Signature of parent/guardian: _____

Date: _____