MAGNOLIA SCHOOL DISTRICT
Magnolia, Arkansas 71753

HEALTH HISTORY & EMERGENCY MEDICAL CARE PERMISSION

STUDENT _____ DATE OF BIRTH _____ TODAY'S DATE _____

PARENT/GUARDIAN _____ GRADE _____

ADDRESS _____

PHONE: Primary _____ Parent's Work _____ Parent's Work _____
Other _____ Cell _____ Cell _____

HEALTH DIAGNOSIS (check any that apply)

ADD/ADHD _____ Heart Disease ____ Diabetes _____

Kidney Disease ____ If yes, please specify _____

Sickle Cell Disease _____ Sickle Cell Trait _____

Glasses ___ Hearing Aides ___ Deaf___ Blind ___

GI Issues: Reflux ___ Vomiting___ Bowel Inconteinence ___

Urinary Issues: Incontinence___ Frequent Urination___

Asthma _____
If yes, does your child require an inhaler at school? _____

Seizures _____
If yes, does your child take medication for seizures? _____
When was your child's last seizure? _____
Does your child require emergency medication (ex. Diastat) to be kept at school for seizures? _____

MEDICATIONS: CONSENT FORM MUST BE COMPLETED FOR MEDICATION AT SCHOOL

Home Meds and dosages: _____

School Medications and dosages: _____

***Parent must bring medication to school to the nurse. ***
Students are <u>not</u> allowed to transport <u>any</u> medications to school.

ALLERGIES (list known allergies of each category)

No known allergies ___ Drug Allegies _____
Seasonal Allergies _____
Food Allergies (<u>if a special diet is required, a dietary needs and food allergy form must be completed by a</u> physician,) _____

Other Allergies:
Bee ___ Fire Ant ___ Wasp ___ Other Insect ___
If you checked any of the above:
What type of reaction has your child had in the past?
_____

*Does your child require Benadryl at school? _____
*Does your child require an Epipen at school? _____

BEHAVIORAL/MENTAL/EMOTIONAL CONCERNS

Diagnosis _____

Therapist/Counselor _____

Bathroom Issues: No ____ Yes _____
Concerns: _____

ANY OTHER CONERNS FOR NURSE:
_____

I authorize this information to be shared with school staff - teachers, administrators, bus drivers, when deemed necessary.
I also authorize sharing of above information with E.M.T's and other emergency care personnel in case of emergency.

In case of sudden illness or accident requiring more attention than normal first aid, if I cannot be contacted, take my child to Doctor _____ or Doctor _____.
local physician local physician

In case of extreme emergency, I authorize the school to call emergency medical services for transportation to the hospital.

As parent/guardian of this student, I am responsible for obtaining and returning medical forms with any health problems listed above and provide necessary medication needed at school to the nurse.
<u>I will notify the school office immediately if any of the above information changes</u>

Revised 2-7-2024

_____ _____
SIGNATURE - PARENT/GUARDIAN **DATE**