

**SPARTANBURG COUNTY SCHOOL DISTRICT 3 - 2010-2011 SCHOOL YEAR
STUDENT MEDICAL ALERT INFORMATION**

Parent/Legal Guardian - Please complete this form and return to the School Health Room:

Student Name: _____ School: _____ Grade: ____ DOB: _____
(Please Print) Last First Middle

Student's Home Address: _____

Transportation to / from school: (Please check one) Bus ___#___ Car ___

<p>(Please circle one) Mother / Legal Guardian Name: _____ Phone: Home _____ Work _____ Cell _____ Address: _____ _____</p>	<p>(Please circle one) Father / Legal Guardian Name: _____ Phone: Home _____ Work _____ Cell _____ Address: _____ _____</p>
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If your child has a Chronic Health Condition or will require medication or monitoring at school, please call the School Nurse at _____ to make an appointment to complete your child's health care plan.

STUDENT HEALTH INFORMATION:

Please check ONLY Health Conditions which apply to your child. Please answer all questions completely.

_____ Asthma - Age at Diagnosis: _____ Age of last asthma attack occurrence: _____

_____ My child does not need an inhaler at school.

_____ My child will not need an inhaler at school.

_____ Allergy to Medication - Please list medication/s your child is allergic to: _____

_____ Allergy to Food - Please list any food your child is allergic to: _____

_____ Allergy to Insect Bites / Bee stings: _____

Has your child ever had a severe allergic reaction to food, insect, or medication which required treatment by his/her physician or required treatment at the emergency room? _____ yes _____ no

Did your physician prescribe an Epi-pen for your child? _____ yes _____ no

_____ Diabetes - Please give a copy your child's diabetes plan of care to the school nurse.

_____ Seizures - Please describe _____

_____ Heart Condition - Please describe _____

_____ Hearing Problems - Please describe _____

_____ Vision Problems _____ Wear glasses _____ Wears Contacts

List Other Health Conditions:

_____ Treatment required: _____

_____ Treatment required: _____

Please complete both sides of this form.



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If your child will need prescription or over the counter medication given at school by the school nurse or other authorized personnel:

- *Please call to make an appointment with the school nurse to complete your child's health care plan.
- *The medication must be prescribed by your child's physician to be given during school hours.
- *The *Authorization for Medication Administration* form must be signed by parent and physician.
- *The medication must be brought to the school by the parent/guardian in the original, properly labeled container.

Please note:

*Additional forms must be completed and signed by parent/guardian, the student, and the student's physician if your child will need to carry an inhaler for asthma or an Epi-pen for severe allergies while at school, on school grounds, at school sponsored activities, or during-before-or-after school activities on school-operated property.

Please list all medications your child takes during school hours:

Parents will be notified when a child is ill and will be expected to make necessary arrangements for immediate transportation home. For the protection of your child, as well as other children, do not send a sick child to school. Please remember the school nurse is not allowed to diagnose an illness. If you have health concerns regarding your child, please consult your child's physician.

Please list three contacts we may call in case of illness.

Name: _____ Relationship: _____ Phone # _____

Name: _____ Relationship: _____ Phone # _____

Name: _____ Relationship: _____ Phone # _____

Please list your child's health care providers:

Doctor: _____ Office Telephone: _____ Office Fax: _____

Doctor: _____ Office Telephone: _____ Office Fax: _____

Optometrist _____ Office Telephone: _____ Office Fax: _____

Dentist: _____ Office Telephone: _____ Office Fax: _____

Hospital: _____

Please read and sign:

In case of an accident or serious illness, I request the school to contact me. By signing below, I give the principal and/or school nurse permission to share my child's health information with physicians, teachers, school officials, and other staff who have a legitimate need to know. I authorize School District officials to contact the individuals named on this form and authorize the named health care providers to render to my child whatever emergency treatment deemed necessary. If the parent or physician cannot be reached, the District officials may take whatever action they deem necessary for the health of my child. I will not hold Spartanburg County School District Three financially responsible for the emergency care and/or transportation of my child. I will keep the school nurse informed of any medical changes throughout the school year. I certify that all information I have provided is correct.

Parent /Legal Guardian Please Print Name

Parent /Legal Guardian Signature

Date

Please complete both sides of this form.

