Estherville Lincoln Central Community Schools

Health Information

Name of Student _____ Birth Date _____ Grade _____

Has your student been diagnosed by a physician for (please circle yes or no):

yes	no	Asthma or bronchospasms	yes	no	ADD/ADHD/behavioral problems
yes	no	Diabetes	yes	no	Seizures/epilepsy
yes	no	Heart problems	yes	no	Migraine headaches
yes	no	Blood pressure problems	yes	no	Depression/Anxiety
yes	no	Kidney/urinary problems	yes	no	Stomach/bowel problems
yes	no	Hearing problems	yes	no	Speech problems
yes	no	Vision/glasses/contacts	yes	no	Skin condition
yes	no	Allergies; reaction(s)			

Comments to any "Yes" items from above or other necessary information _____

Medication:	Dose/Frequency:	Condition taken for:

Date of last physical _____
Date of last vision exam _____
Date of last dental exam _____
Name of Doctor/phone _____
Name of Dentist/phone _____
Other _____

Has your student had any surgery, serious illness or injury, or health or emotional concerns?

Does your child have: Private insurance _____ Medicaid_____ No Insurance_____ Other_____

Name of insurance / policy number: _____

If you DO NOT doctor in Estherville, may an Estherville doctor be called, especially in case of emergency? YES NO

In case of an emergency an ambulance will be called at your expense.

I give my permission to the school to share information relevant to my child's health condition with appropriate school personnel and AEA staff when needed to meet my child's health and safety needs. I give my permission to medical professionals to exchange information for the purposes of referral, diagnosis, and treatment with the Estherville Lincoln Central School Nurse. I give specific permission to my care provider to share any pertinent health information in my child's health record regarding: immunizations, administration of medications, and/or educationally significant health information that may affect my child's learning and/or safety at school. I give my permission to the school to give my child First Aid. If deemed necessary, staff also has permission to use sunblock and/or bug spray for my child.

I understand a school representative may call 911 in case of emergencies.
Please list contact numbers for yourself and others, in case we are unable to reach you:

Name:_____Phone#_____ Name:_____Phone#_____
Name:_____Phone#_____ Name:_____Phone#_____
Name:_____Phone#_____ Name:_____Phone#_____

_____ _____
Signature of parent/guardian Date

Apr-15

(Please Complete Both Sides)

Estherville Lincoln Central Community School District

Medication Form for 3rd - 12th Grade

Grade: _____

The following may be given to my child, _____, for illness during school time.
(Name of student)

Please put an X in the "Yes" or "No" column.

MEDICATIONS FOR 3RD THROUGH 12TH GRADE

1. Minor discomfort (headache, toothache, etc.)

Tylenol 325 mg - 1 or 2 tablets according to age and weight, every 4 hours as needed	Yes _____	No _____
Ibuprofen 200 mg - 1 or 2 tablets according to age and weight, every 4 hours as needed (with crackers or snack)	Yes _____	No _____

2. Mild gastric upset

Antacid chewable tablet	Yes _____	No _____

3. Menstrual cramps (girls only)

Midol - 1 or 2 tablets every 4 hours as needed	Yes _____	No _____
OR		
Ibuprofen 200 mg - 1 or 2 tablets according to age and weight, every 4 hours as needed (with crackers or snack)	Yes _____	No _____

{Follow guidelines used for first aid, sorethroats, abrasions, etc. as recommended by American Red Cross and or American Heart Association.}

My child has not experienced any side effects from this medication. I agree to allow the qualified personnel to dispense the above medication to my child if it is determined that it may be helpful to my child. I understand that I will be notified if my child's complaints become worsening or frequent. I understand that I will be asked to supply the school with the above medications if my child's complaints become frequent, but needed. The school has the right to deny these medications to a student due to frequent, or invalid complaint(s).

Date: _____ Signature: _____

This form must be signed and returned to the school nurse before the above medications will be administered by school personnel.

(Please Complete Both Sides)