2017-2018

CONFIDENTIAL

Student Name: ______________________________ Birth date: _______________ Grade: _________

Gender: ____________________________ Name of Doctor: ___________________________________

Please check if your child has had the following:

Condition	Yes	No	Year	Condition	Yes	No	Year
High Blood Pressure				Heart Condition			
Asthma				TB or contact with TB			
Severe Allergies				Severe or chronic stomach problems			
Frequent or painful urination				Wets or soils pants			
Concussion				Frequent or severe headaches			
Dizzy or fainting spells				Severe head injury			
Epilepsy				Excessive worry or anxiety			
Depression				Hearing loss			
Speech Problems				Eye problems			
Frequent ear infections				Frequent colds			
Wears glasses or contacts				Diabetes			
Scoliosis				Tumor			
Cancer				Serious skin disease			

1. Has your child ever had any serious illnesses or injuries other than those already noted? What? When?
   Explain: ____
2. List any allergies to food, medications, or bee stings.
   Explain: ____
3. List any medications your child currently takes or needs for allergies:
   Explain: ____

Dear Parent/Guardian:

According to State Law 18A:40-4, your child will be examined periodically by our school doctor and nurse together. This may require the loosening of clothing to the waist for adequate examination. If you have any objection because of religious beliefs or otherwise, you must file a written statement at the school office.

Please sign:

____ _______________

Signature of Parent/Guardian Date

SCHOOL NAME

Brookdale

PARENT RELEASE FOR MEDICAL INFORMATION

Student's Name:________________________ Date ___________________

School:________________________________ Location________________

I hereby grant permission to the school nurse to contact my child's physician concerning any medical matter pertaining to my child's welfare in school. I hereby grant permission to the school Nurse to release all pertinent medical information (medications, concerns, medical conditions, etc.) to the appropriate school staff who interact with my child__________________________.

Physician Name____

Address ____

____

Telephone# ____

___________________________________ _________________________

Parent/Guardian Signature Date