

# Kearney R-1 School District

## Confidential Student Medical Information & Consent

School \_\_\_\_\_ School Year \_\_\_\_\_

Student Name \_\_\_\_\_ DOB \_\_\_\_\_ Grade \_\_\_\_\_ Teacher \_\_\_\_\_

Parent/Guardian \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

### Medical Diagnosis by Physician: (Check all that apply)

<input type="checkbox"/> Asthma Last event _____ <input type="checkbox"/> *Food Allergy <input type="checkbox"/> EpiPen® <input type="checkbox"/> Benadryl® <input type="checkbox"/> Chronic Ear Infections <input type="checkbox"/> History of Head Injury <input type="checkbox"/> Hemophilia	<input type="checkbox"/> Allergies <input type="checkbox"/> Heart Condition <input type="checkbox"/> Hearing Impairment <input type="checkbox"/> Hearing Aide(s) <input type="checkbox"/> Bone Disease <input type="checkbox"/> Depression <input type="checkbox"/> Chronic Pain	<input type="checkbox"/> ADD/ <input type="checkbox"/> ADHD <input type="checkbox"/> Cancer _____ <input type="checkbox"/> Seizure Disorder <input type="checkbox"/> Migraine Headaches <input type="checkbox"/> Diabetes <input type="checkbox"/> Pump <input type="checkbox"/> Pen <input type="checkbox"/> Bowel/ Bladder Problem	<input type="checkbox"/> Visual Impairment <input type="checkbox"/> Contacts <input type="checkbox"/> Glasses <input type="checkbox"/> Kidney Problems <input type="checkbox"/> Gastrointestinal Disorder <input type="checkbox"/> Emotional Disorder <input type="checkbox"/> Surgery <input type="checkbox"/> Other _____
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Pertinent medical information that might affect your child's day while at school

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Allergies to \*food or medication(s)

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Current medication(s) and reason for taking

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Physician	Phone	Last seen
Specialist	Phone	Last seen
Dentist	Phone	Last seen

Preferred Hospital \_\_\_\_\_

I give permission for the above information to be shared in confidence with appropriate staff and emergency personnel. In the event of an emergency, I authorize school personnel to obtain emergency medical care and/or emergency transportation by ambulance to the above named hospital.

**Parent Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

*\* If your child has a disability, or medical condition, including food allergies that require a special diet, you must submit a Medical Statement for Student Requiring Special Meals form. Form must be completed by your physician for the omission and/or substitution of any food(s).*

**For grades 6<sup>th</sup>-12<sup>th</sup> ONLY**  
 See reverse to give permission for your child  
 to receive over-the-counter pain relievers while at school

Student Name \_\_\_\_\_ DOB \_\_\_\_\_ Grade \_\_\_\_\_

**GRADES 6-12 ONLY**

**Authorization for Administration of Over-the-Counter Pain Reliever**

This is to request a district designee to administer the over-the-counter medication indicated below. Over the counter medications will be documented and evaluated throughout the academic year and will be dispensed **only with signed permission** from a parent/guardian. This document must be renewed with each academic year. There will only be 20 doses given to a student in an academic year. Parents will be notified after the 15<sup>th</sup> dose has been administered. **Doses may be withheld at the discretion of the district designee.** Please refer to the district policies on-line for the written practice of dispensing acetaminophen and ibuprofen in the Kearney School District.

My Child may receive the following over the counter medication:

\_\_\_\_\_ Ibuprofen 200 mg (i.e. Advil)                      Please circle    1 tablet or 2 tablets  
 \_\_\_\_\_ Acetaminophen 325 mg (i.e. Tylenol)                      Please circle    1 tablet or 2 tablets

Known Allergies to medications \_\_\_\_\_

Parent/Guardian signature \_\_\_\_\_

**\*\*The Kearney R-1 School District will not be held accountable for the dispensation of over the counter pain relievers in accordance with a signed permission form from the parent/guardian. Upon submission of the signed release for dispensation, the parent is responsible to notify the district in writing should this allowance need to be discontinued. Permission forms are good for one academic year and must be renewed annually.**

	Date	Time	Dose	Tyl/Ibu	Initials		Date	Time	Dose	Tyl/Ibu	Initials
1				Tyl/Ibu		8				Tyl/Ibu	
2				Tyl/Ibu		9				Tyl/Ibu	
3				Tyl/Ibu		10				Tyl/Ibu	
4				Tyl/Ibu		11				Tyl/Ibu	
5				Tyl/Ibu		12				Tyl/Ibu	
6				Tyl/Ibu		13				Tyl/Ibu	
7				Tyl/Ibu		14				Tyl/Ibu	
						15				Tyl/Ibu	
	15 dose	Notification	Date	Time	Notified		Parent/Guar.	Initials			
16				Tyl/Ibu							
17				Tyl/Ibu							
18				Tyl/Ibu							
19				Tyl/Ibu							
20				Tyl/Ibu							

Initials \_\_\_\_\_ Signature \_\_\_\_\_ Initials \_\_\_\_\_ Signature \_\_\_\_\_

Initials \_\_\_\_\_ Signature \_\_\_\_\_ Initials \_\_\_\_\_ Signature \_\_\_\_\_