

# North Andrew R-VI Enrollment, Health, Emergency & Permission Form

## STUDENT INFORMATION:

Student's Legal Name: First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_  
Grade: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Student's Primary Language: \_\_\_\_\_ Male: \_\_\_\_\_ Female: \_\_\_\_\_

## PARENT INFORMATION:

**Primary Parent/Guardian Name:** \_\_\_\_\_  
\_\_\_\_ Mother \_\_\_\_ Father \_\_\_\_ Step-Mother \_\_\_\_ Step -Father \_\_\_\_ Guardian \_\_\_\_ Foster Parent \_\_\_\_ Host Parent  
Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_  
Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Employer Name: \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ (Ext) \_\_\_\_\_

**Primary Parent/Guardian Name:** \_\_\_\_\_  
\_\_\_\_ Mother \_\_\_\_ Father \_\_\_\_ Step-Mother \_\_\_\_ Step -Father \_\_\_\_ Guardian \_\_\_\_ Foster Parent \_\_\_\_ Host Parent  
Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_  
Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Employer Name: \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ (Ext) \_\_\_\_\_

**Other Parent – Not in the Home:** \_\_\_\_\_  
\_\_\_\_ Mother \_\_\_\_ Father \_\_\_\_ Step-Mother \_\_\_\_ Step -Father \_\_\_\_ Guardian \_\_\_\_ Foster Parent \_\_\_\_ Host Parent  
Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_  
Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Employer Name: \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ (Ext) \_\_\_\_\_

If divorced, who has legal custody? \_\_\_\_ Mother \_\_\_\_ Father

WHERE WILL YOUR CHILD GO IF SCHOOL GETS OUT EARLY? \_\_\_\_\_

## IN CASE OF EMERGENCY CALL: *(Persons whom you give permission to check out or pick up students for appointments, illness or emergency)* \*\*\*Must not be a current student and must be over the age of 18\*\*\*

Name \_\_\_\_\_ Phone \_\_\_\_\_  
Name \_\_\_\_\_ Phone \_\_\_\_\_  
Name \_\_\_\_\_ Phone \_\_\_\_\_  
Name \_\_\_\_\_ Phone \_\_\_\_\_

In the event that your child has an accident or becomes ill at school, please list the physician to be called.

Physician \_\_\_\_\_ Phone \_\_\_\_\_  
Dentist \_\_\_\_\_ Phone \_\_\_\_\_

Date of Last Physical \_\_\_\_/\_\_\_\_/\_\_\_\_ Last Tetanus Shot \_\_\_\_/\_\_\_\_/\_\_\_\_ Last Dental Check -up \_\_\_\_/\_\_\_\_/\_\_\_\_

My child has permission to have vision, hearing, dental, speech/language, etc. screening test YES \_\_\_\_\_ NO \_\_\_\_\_

## PRESENT HEALTH CONDITIONS:

**Bee Sting Allergy** Yes \_\_\_\_ No \_\_\_\_ Describe reaction \_\_\_\_\_  
Difficulty breathing? Y\_\_N\_\_ Emergency medication needed? Y\_\_N\_\_  
**If YES Bee Sting allergy form must be completed**

**Food Allergy** Yes \_\_\_\_ No \_\_\_\_ To what? \_\_\_\_\_  
Difficulty breathing? Y\_\_N\_\_ Emergency medication needed? Y\_\_N\_\_  
**If YES Food allergy form must be completed**

**Asthma** Yes \_\_\_\_ No \_\_\_\_ Triggered by \_\_\_\_\_  
Treatments \_\_\_\_\_  
Diagnosing Dr. name \_\_\_\_\_ Phone# \_\_\_\_\_  
**If YES Asthma care plan form must be completed**

**OVER**

Other Present Health Concerns \_\_\_\_\_

Diabetes YES / NO    Epilepsy/Seizure Disorder YES / NO    Heart Condition YES / NO    Bone/Joint Condition YES / NO  
**If yes to any of the above illnesses please be specific about condition below.**

Past Medical History (Injuries, Hospitalization/Operation, Health Problems) \_\_\_\_\_

List any other allergies your child has (Medications , environmental, etc.). \_\_\_\_\_

List any medications and dosage your child currently takes \_\_\_\_\_

We have the following medications available at school to treat minor illness/injuries. **If you prefer your child not to receive one of these or he/she has an allergy, please indicate in the space below.** We must have a parents/guardians signature at the bottom of this page before we can give any medication.

- |  |                             |                       |                                   |
|--|-----------------------------|-----------------------|-----------------------------------|
| <b><u>*Generic versions may be used.</u></b> | *Campho-phenique            | *Tylenol              | *Eye Wash/Artificial Tears/Visine |
| *Epi-pen (severe allergic reactions.)        | *Vaseline/Blistex           | *Ibuprofen            | *Similasan Ear Drops              |
| *Albuterol(severe asthma episode)            | *Solarcaine Spray           | *Cough Drops          | *Anbesol/Oragel/Orasol            |
| *Benedryl (minor allergic reactions)         | *Aloe Vera                  | *Robitussin           | *Vick’s Vapor Rub                 |
| *Caladryl/Calamine Lotion                    | *Triple Antibiotic Ointment | *Tums                 | *Chloroseptic                     |
| *Hydrocortisone 1% Cream                     | *Peroxide                   | *Sore Throat Lozenges | *Wound cleansers/Saline           |

\*Decoral Forte (Acetaminophen, Dextromethorphan, Guaifenesin, Phenylephrine) \* Medicidin-D (Acetaminophen, Chlorpheniramine Maleate, Phenylephrine)

Regarding Epi-Pen **PLEASE NOTE::** Epi-Pen administration is Board approved and WILL BE ADMINISTERED IN THE EVENT OF AN ANAPHYLACTIC REACTION (which is an emergency).

Please list any items above you do not want your child to have: \_\_\_\_\_

Authorization is given to North Andrew R-VI to consent to medical treatment for my child \_\_\_\_\_ if we the parents/guardians are not available at the time of injury/illness. Our private physician or a consulting physician of his/her choice recommends admission to the hospital; we authorize admission to any hospital for our child at the time of an injury/illness in our absence. We, the parents/guardians, will be responsible for the charges for any medical treatment or hospitalization rendered by reason on this authorization.

Insurance Company & Policy # \_\_\_\_\_

Missouri Health Net/Medicaid # \_\_\_\_\_

**Please mark if you do not have Insurance.**

Legal Signature of Parents/Guardians:  
Consent for Medical Treatment must be **signed in the presence of** a notary public. (One signature required, two recommended.)

Signature \_\_\_\_\_

Signature \_\_\_\_\_

Subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

\_\_\_\_\_  
Notary Public

**If you do not get this form SIGNED and NOTORIZED the health office cannot treat your child with any medication!**