

# Student Visitation Form



We are pleased to have your child(ren) visit Post Oak. For your child's health and wellness, we ask families to complete the form below. Please use a separate form for each child visiting the school.

Child's name: \_\_\_\_\_ Age/grade: \_\_\_\_\_

Parents'/guardians' names: \_\_\_\_\_

Mobile numbers: \_\_\_\_\_

Alternate emergency contact: \_\_\_\_\_

(Name, relationship to child, and number)

## MEDICAL/HEALTH INFORMATION

Check ALL that apply, and return with the required action/care/management plan(s) from your medical provider.

☐ **Asthma** ☐ Intermittent ☐ Exercise induced ☐ Uses an inhaler ..... *Asthma Action Plan* required

☐ **Diabetes** ☐ Type 1 ☐ Type 2 ☐ Uses a pump/insulin ☐ CGM ..... *Diabetes Management Plan* required

☐ **Seizure** Type: ..... *Seizure Care Plan* required

☐ **Allergies** ☐ Food ☐ Insect ☐ Latex ☐ Medication ..... *Allergy Care Plan* required

List allergen(s): \_\_\_\_\_

☐ **Other chronic medical conditions** requiring an action plan: \_\_\_\_\_

If you checked *any* of the above conditions, you must provide the school with a care plan, completed and signed by the medical provider, as well as any necessary medication.

### *Additional Medical Information*

☐ History of concussion: Date occurred \_\_\_\_\_ Cleared by medical provider ☐ Yes ☐ No

☐ Hospitalizations during the past 12 months: \_\_\_\_\_

☐ Existing illnesses: \_\_\_\_\_

☐ Previous illnesses and injuries. Please include any chronic conditions not listed above, special healthcare needs (e.g. any speech, OT, or physical therapy they may receive), medical devices they may rely on, etc. \_\_\_\_\_

☐ Surgical history: \_\_\_\_\_

☐ Other: \_\_\_\_\_

*This form, completed and signed, along with care plan(s), is required for treatment of above checked health concerns and administration of required medications.*

If you checked *any* boxes above, please complete and sign the following.

I the undersigned parent, \_\_\_\_\_, do hereby give my authorization and consent to The Post Oak School to administer medication provided by me as deemed necessary during the course of my child's visit at the school. I have also provided the action/care/management plan for each condition requiring one.

Signature of Parent or Guardian

Date