O'Fallon District 90
Learning today, leading tomorrow

Carrie Hruby
SUPERINTENDENT

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Student Name: _____ School: _____ Grade: _____

D.O.B: _____ Sex: _____ Previous School: _____ State: _____

Parent Name (in home): _____/_____

(Please circle) Father, Step Father, Guardian Mother, Step Mother, Guardian

Address: _____ Phone: _____

PERMISSION FOR TREATMENT

I, _____, parent or legal guardian of _____
Parent/Guardian Name *Student Name*
am a resident of the O'Fallon School District 90 and enroll my child in District 90. I hereby authorize, and consent to School District 90, its employees and agents, and _____, my child's licensed health-care
Provider
provider or any licensed provider in his or her group practice, or emergency personnel, in my behalf and in my stead, to administer first aid or emergency medical assistance to my child. This permission and consent extends to the right of School District 90, its employees and agents to arrange for immediate medical treatment by a licensed or certified physician and/or other medical personnel and for such physician or other medical personnel to apply such emergency techniques which, in their judgment, they deem appropriate to treat any injury sustained by my child.

I do hereby agree to hold harmless and indemnify the school district, its employees and agents, either jointly or severally from and against any and all claims, demands, damages, or causes of action or injuries, resulting from or arising out of the provision of emergency medical treatment by school personnel or by a physician and/or other medical personnel.

In case the school officials are unable to contact me (parent/guardian) or any of the designated emergency contacts and my child needs to be transported to a hospital, decisions will made in the best interest of the child. The law in the State of Illinois states the EMS must transport to the nearest hospital. The person can then be transported to the hospital of my choice.

First Hospital Choice: _____ Second Hospital Choice: _____
Medications: _____
Allergies to medications: _____
Allergies: Food _____ Other _____
Symptoms of Allergic Reactions: _____
Health Concerns/Diagnosis: _____

The information on this page and the reverse side may be shared with administrative, educational and emergency personnel.

Signature: _____ Date: _____
This form should be placed in the health folder.

PLEASE COMPLETE BOTH SIDES OF THIS FORM

Revised 1/2019

Student Name: _____ **Birth Date:** _____

MEDICAL HISTORY

ALLERGIES: (Food, Drug, Insect, Other)

Reaction:

Food: ____ Airborne ___ Contact ___ Ingestion **Epipen?** Y N

Can student have food processed in a facility with the allergen? Y N

MEDICATION:
(List all prescribed or over the counter taken on a regular basis)

Home:

School:

Diagnosis of Asthma? Y N Inhaler use? Y N ___ Home ___ School Asthma Action Plan? Y N

Triggers: *If yes, provide school a copy.*

Birth Defects Y N _____

Developmental Delay Y N _____

Blood Disorders? Hemophilia, Sickle Cell, Other. Y N (please explain)

IEP or 504 Plan? Y N _____

Loss of function of one of paired organs (eye; ear; kidney; testicle) Y N _____

Hospitalizations Y N (please explain)

Diabetes Y N Type: I II ___ CGM ___ Blood sugar testing ___ Insulin injection ___ Insulin pump

Head Injuries Y N

___ concussion (age & treatment) _____

___ skull fracture (age & treatment) _____

Surgeries Y N (please explain)

Seizures Y N Type: _____

Seizure Action Plan? Y N *If yes, provide school a copy.*

Serious injury or illness Y N (please explain)

Heart Problems

Shortness of Breath Y N

Heart Murmur Y N Restrictions? Y N

High blood pressure Y N

Dizziness or chest pain with exercise Y N Restrictions? Y N

TB skin test positive Y N Year_____

TB disease Y N Year_____

Treatment:

Eye/Vision Problems Y N Last exam _____

___Glasses ___ Contacts ___Amblyopia (lazy eye)

___ Loss of Vision ___right eye ___left eye

Ear/Hearing Problems Y N

___hearing loss ___right ear ___left ear

___hearing aids ___right ear ___left ear

Bone/Joint problems/ injury; scoliosis? Y N (please explain)

Family tobacco use Y N

Alcohol/Drug use Y N

Family history of sudden death before age 50; explain Y N

Dental: Last exam _____

___ Braces ___ Bridge

____ Plate ____ Other _____

Last medical exam _____ Physician: _____

Childhood Illnesses: ___ Chickenpox (yr)_____

___ Pertussis or Whooping Cough (yr)_____

Other Concerns:

Information may be shared with appropriate personnel for health and educational purposes. I further give permission for school medical personnel to contact my medical providers during the school year to clarify or receive guidance on immunization status, ER visits, and treatment impacting care at school.

Parent/Guardian Signature _____ Date _____ Phone: _____

Revised 2/2020