RICHLAND SCHOOL DISTRICT TWO
HEALTH UPDATE
2023-2024

PLEASE PRINT CLEARLY

Child's Name _____ *First* *Middle* *Last*	**Date of Birth** _____

School	**Grade**	**Homeroom teacher**	**Email Address**
Mother's Name	**Home phone**	**Cell phone**	**Work phone**
Father's Name	**Home phone**	**Cell phone**	**Work phone**
Emergency contact Name	**Home phone**	**Cell phone**	**Work phone**
Emergency contact Name	**Home phone**	**Cell phone**	**Work phone**

What type of health insurance coverage does your child have?
☐ *Medicaid* ☐ *Other Private Health Insurance* _____ ☐ *Tricare* ☐ *None*

Does your child's health insurance pay for: Vision Exams? ☐ *Yes* ☐ *No* *Glasses?* ☐ *Yes* ☐ *No* *Prescriptions?* ☐ *Yes* ☐ *No*

Does your child have a regular doctor? ☐ *Yes* ☐ *No*
Doctor's name _____ Name of practice _____ phone: _____

Hospital preference
_____

Does your child have any **severe allergies to food, medications, insects**, etc.?
☐ Yes ☐ No
Please **list severe allergies**

What **medications** does your child take for the **allergic reaction**?
_____
_____
Will you be providing an EpiPen for school?
☐ Yes ☐ No

Does your child have asthma?
☐ Yes ☐ No
When was his/her **last attack**? _____

Will you be providing an inhaler for school?
☐ Yes ☐ No

Has your child had any surgeries?
☐ Yes ☐ No
If so, please list:
_____
_____

I give permission for the following topical applications:

☐ Yes ☐ No Anti-itch topical

Is your child taking daily medications?
☐ Yes ☐ No
If so please list:
_____

Will they need to be taken at school?
☐ Yes ☐ No

Does your child have any **identifying marks?**
☐ Yes ☐ No
If so, please list:
_____
_____
_____

Does your child have any of the following **physician diagnosed health conditions?**

Condition	Please check if "Yes"	Condition	Please check if "Yes"
Diabetes		**Seizure Disorder**	
Headaches		**Sickle Cell Anemia**	
Heart Problems		**Stomach/ Digestive**	
High Blood Pressure		**Other**	

District Medication Policy: Medication must be in a properly labeled **original** container, This includes prescription and over the counter medication. A completed school Medication Permission Form is required for **ALL** medications. Prescription medications require a physician's signature in addition to the parent's signature.

Medication will not be administered without the above requirements being met. The district reserves the right to refuse to administer medications at school until the physician has signed the forms.

THIS INFORMATION WILL BE KNOWN ONLY TO THE SCHOOL NURSE AND TO HEALTH ROOM PERSONNEL. FOR YOUR CHILD'S SAFETY, HIS/HER TEACHERS AND OTHER PERTINENT SCHOOL PERSONNEL MAY BE NOTIFIED. IF YOU DISAGREE WITH THIS OR HAVE QUESTIONS, PLEASE LET THE SCHOOL NURSE KNOW.

Parent/Guardian signature _____**Printed Name**: _____**Date** _____

Form Updated Nov 2022