



Student Name: _____ Date of Birth: _____ Grade: _____ Teacher: _____

Parent/Guardian Name (Print): _____ Phone: _____

Parent/Guardian Name (Print): _____ Phone: _____

Emergency Contact: _____ Phone #: _____

Primary Email: _____ Secondary Email: _____

Doctor: _____ Hospital: _____ Insurance: Private _____ Medicaid/AR Kids: _____

Medically Diagnosed Conditions	Current	Past (Year)	Never	Medically Diagnosed Conditions	Current	Past (Year)	Never
ADD/ADHD				Heart Condition / Heart Surgeries			
*Asthma				High/low blood pressure – blood issues			
Balance issues; leg braces, wheelchair, etc.				Intestinal Issue/Constipation/Encopresis			
*Diabetes or Sugar in urine				Loss of family, divorce/separation, move			
Dizziness or Fainting spells				Seasonal Allergies, hay fever			
Dyslexia (include medical documentation)				Severe behavioral issues			
Eczema, Skin disease				*Severe Allergies (Requires Epi-Pen)			
*Epileptic seizures / convulsions				Severe or Chronic Abdominal Pain			
COVID-19: had disease or 2 vaccines?				Severe Head injury / Concussion			
Frequent ear infections / Ear tubes				Tumor, Growth, or Cancer			
Frequent or Painful Urination				Wears Glasses/Contact lenses			
Frequent, Severe Headache				Wets or Soils Pants day or night			
Hearing loss / Hearing aids				Worry, anxiety/depression, sleep issues			

***It is mandatory, students with Asthma, Diabetes, Anaphylaxis, Seizures, etc., have an updated health care plan on file.**

Explain health conditions or surgeries: _____

Has your child received recent immunizations: Y _____ N _____ Filed for Arkansas Immunization Exemption? Date: _____ Give copy to RN

List current medications your child takes regularly/daily at home or at school:MedicationDosage & FrequencyPurposeSide Effects**List any Allergies to *foods or medications (Prescription or over the counter):**

Allergy: _____ Reaction: _____ *Recommended Medication: Benadryl: _____ Epi-Pen: _____

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Check SCREENINGS you DO NOT want for your child: _____ BMI (K,2,4,6,8,10) _____ Scoliosis (Girls -6 & 8 and Boys-8)

This consent must be signed for school to adhere to doctor-ordered care plans and for student to receive over the counter medications. Over the counter medications and emergency Epinephrine and Narcan are available to your child per nurse's assessment. Dosages are based on label instructions and are approved by Dr. Curtis Hedberg. **If your child needs any scheduled prescription or non-prescription medications during the school day, a parent or guardian MUST bring medication to the nurse in the original container, ALONG WITH written prescribed orders by an Arkansas Licensed Healthcare Professional.** I hereby authorize any/all medical providers of the Student, for which I am the parent or legal guardian, to confer with and/or release information and records regarding said Student's health care to any representative of the Bentonville School District requesting such information and records. I understand that the above information may be released to appropriate School District employees and emergency personnel in order to facilitate health care for my child. I also understand that in the event of an emergency, EMS will treat and transport my child to the nearest hospital. The hospital and its medical staff have my authorization to provide treatment necessary for the well-being of my child.

Parent/Guardian Signature: _____ Date: _____

Office use only

504: _____ IHP: _____ Processed by: _____ Date: _____