salem SA academy CHARTER SCHOOL

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Health Information Form

Student Name

Doctor's Name/Health Center | Doctor's Phone Number

Preferred Hospital

Name of Health Insurance | Health Insurance Policy #

Name of Dentist | Dentist's Phone Number

1. Does the student have any allergies to medication or food (If yes, please list below)?

1. Do any of the student's family/household members have any major health problems?
   ☐ Yes ☐ No If yes, please describe:

2. Has the student had any of the following illnesses or conditions?

Accidents	☐ Yes	☐ No	Bowel Problems	☐ Yes	☐ No
Allergy	☐ Yes	☐ No	Anemia	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Sickle Cell	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Seizures	☐ Yes	☐ No
TB	☐ Yes	☐ No	Frequent Headaches	☐ Yes	☐ No
G6PD	☐ Yes	☐ No	Skin Problems	☐ Yes	☐ No
Lead Poisoning	☐ Yes	☐ No	Behavioral Problems	☐ Yes	☐ No
Heart Problems	☐ Yes	☐ No	Birth Defect	☐ Yes	☐ No
Menstrual Problems	☐ Yes	☐ No	Kidney/Urinary Problems	☐ Yes	☐ No
Learning Problems	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Weight Problems	☐ Yes	☐ No	Ear/Throat Infections	☐ Yes	☐ No
Hospitalizations	☐ Yes	☐ No	Respiratory Infections	☐ Yes	☐ No
Dental Problems	☐ Yes	☐ No	Bone/Joint Problems	☐ Yes	☐ No

Please describe in more detail, any of the above items that are marked 'Yes:'

Hearing / Vision / Speech

Has this student had convulsions or seizures?	□ Yes	□ No
Has this student had a hearing test?	□ Yes	□ No
Does this student have a hearing problem?	□ Yes	□ No
Does this student have a vision problem?	□ Yes	□ No
Has this student had a vision test?	□ Yes	□ No
Does this student wear glasses?	□ Yes	□ No
If yes: ___Full Time ___Reading ___Distance ___Other		
Does this student receive preferential seating for a vision/hearing problem?	□ Yes	□ No
Does this student receive speech therapy?	□ Yes	□ No

Please describe in more detail, any of the above items marked 'Yes:'

3. Does this student have any special needs that the School Health Program should be aware of? (For example, is it necessary to limit activity?)

4. Is this student taking any medication on a daily basis? □ Yes □ No
If yes, please specify:

6. Has the student had Chicken Pox Disease? □ Yes □ No

If yes, date of disease: _____

If yes, a physician certified history must be on file at the school.

Please be aware that there may be times when it will be necessary to share some of this information with school administrators, teachers, or other members of the school faculty and staff. If there is any reason you would not want this information shared, please contact the school.

If medication (including Tylenol, aspirin, and asthma inhalers) is to be administered at school, an Authorization to Dispense Medication form must be completed by the prescriber/doctor and the parent/guardian. All medication must be given to the nurse or Office Manager by a parent/guardian in the original container. Children must never carry medication.

I give permission to Salem Academy Charter School the consent for treatment in the event of a medical or psychiatric emergency. I give permission for transport via ambulance in case of such an event. I give permission to the school to administer my child's medication, to share information relevant to the prescribed medication, to determine if self-administration of medication is safe and appropriate for my child's health, and to allow self-administration of medication. I understand that medication may be destroyed if it is not picked up within one week following termination of the order or one week beyond the end of the school year. I hereby release Salem Academy Charter School, its staff members, and its officers from liability associated with administration of my child's medication and/or with medical treatment for my child.

_____ _____ _____

Parent/Guardian Name Parent/Guardian Signature Date