

**HEALTH CARD** (please answer all questions)

SCHOOL YEAR: \_\_\_\_\_

Name: \_\_\_\_\_ M F Teacher: \_\_\_\_\_ Grade: \_\_\_\_\_  
(Last) (First) (MI)

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Medicaid or AR Kids #: \_\_\_\_\_

Address: \_\_\_\_\_

Parent/Guardian Name(s): \_\_\_\_\_ Home Phone Number: \_\_\_\_\_

Father's Employer: \_\_\_\_\_ Phone: \_\_\_\_\_ Cell #: \_\_\_\_\_

Mother's Employer: \_\_\_\_\_ Phone: \_\_\_\_\_ Cell#: \_\_\_\_\_

Authorized Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Authorized Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Do you have health insurance? YES NO

Does your child ride a bus? YES NO

Does student have a **current** medical diagnosis of any of the following conditions? Check all that apply

- ASTHMA                                      ADD/ADHD                                      WEAR CONTACTS/GLASSES
- DIABETES                                      BLOOD DISORDER                                      HEARING LOSS      RIGHT      LEFT      HEARING AID
- HEART CONDITION                                      CEREBRAL PALSY                                      **ALLERGY TO MEDICATION/FOODS:** \_\_\_\_\_
- SEIZURES                                      KIDNEY DISORDER                                      OTHER (specify): \_\_\_\_\_
- SEVERE OR LIFE-THREATENING ALLERGY TO NUTS, LATEX, OR STINGS (specify): \_\_\_\_\_

What medication(s) is your child currently taking? \_\_\_\_\_

Do you authorize the use of **Calamine Lotion, Ibuprofen, Tylenol, Hydrogen Peroxide, Hydrocortisone/Anti-itch Cream, Triple Antibiotic Ointment, Aloe Vera, Tums, Vicks Salve, Benadryl, Orajel, Lotion/Vaseline, Carmex/Chap stick, Eye Drops/Wash, Liquid Simethicone Drops (for gas), Diet Cranberry Juice, Deodorant, Salt Water Gargle, or Cough Drops if needed?**

**YES      NO      Please mark through any medication you may not want your child to receive.**

I acknowledge that the Ozark Mountain School District, the Board of Directors, and School Employees shall be immune from civil liability for damages resulting from the administration of medications in accordance with this consent.

**I will notify the school of any change in address, phone number, emergency contact or my child's health status.** 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 that a physician deems necessary for the well-being of my child.

**In compliance with the Family Education Rights and Privacy Act (FERPA) (20U.S.C. & 1232g; 34 CFR Part 99), I give permission for my child's personally identifiable information/student education records to be disclosed to ISEP for the purpose of billing Medicaid and/or private insurance.**

**In compliance with the Family Education Right to Privacy Act (FERPA) (20 U.S.C. § 1232g; 34 CFR Part 99) I give permission for my child to participate in the School Immunization Clinic. I understand that the appropriate Arkansas Department of Health consent forms will be provided for my consideration prior to the clinic.**

Date: \_\_\_\_\_ Signature of Parent/Guardian: \_\_\_\_\_