SOUTH SD DEARBORN
Community School Corporation

6109 Squire Place, Aurora, IN 47001 www.sdcsc.k12.in.us T: 812-926-2090 F: 812-926-4216

# Permission to Treat/Health Appraisal Form – Page 1 of 2

Student's Name: _____ DOB: ___/___/___

Address: _____

Parent's Name: _____

Parent's Address: _____

Siblings: _____

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#1 Emergency Contact: _____ Relation: _____
(Other than parents) Phone #: _____
#2 Emergency Contact: _____ Relation: _____
(Other than parents) Phone #: _____

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**Health Conditions:** ***please check any that this child has had:***

__ Abnormal spinal curvature
__ ADD/ADHD
__ Allergies (seasonal)
__ Allergies (food)
__ Asthma/Reactive Airway Disease
__ Autism
__ Behavior concerns
__ Bleeding Disorder
__ Cancer, Type _____
__ Cerebral Palsy
__ Cystic Fibrosis
__ Dental Appliance/Braces
__ Depression
__ Developmental Delay
__ Diabetes
__ Down's Syndrome
__ Eating Disorder
__ Eczema
__ Glasses/contacts
__ Headaches/migraines
__ Hearing Aid/Implant
__ Hearing Deficit
__ Heart Concerns
__ Immunodeficiency Disease
__ Inflammatory Bowel Disease
__ Insect Allergy
__ Kidney Concerns
__ Learning Concerns
__ Meningitis
__ Cognitive Disability
__ Anemia
__ Nose Bleeds
__ Orthopedic concerns
__ Seizures
__ Sickle Cell
__ Spina Bifida
__ Stool soiling
__ Multiple Birth
__ Vision Concerns
__ Blindness
__ Color Blind

1. Allergies: My child is allergic to: _____
   Treatment for the allergy: ____ Benadryl ___ Epi-Pen ___ Other (please describe)
   ___ I will bring the medications to school for my child to keep in the office.
   ___ I would like to meet with the nurse to discuss my child's allergy.

2. Medications:
   What medications are given daily at home? _____ _____
   Reason medication is prescribed? _____
   What medications are needed during school? _____
   Reason medication is prescribed? _____

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3. Asthma/Reactive Airway Disease:
   __ The student will keep an emergency inhaler in the office.
   __ The student will need to use an nebulizer as needed at school.
   __ The student will carry an emergency inhaler on self – ***requires a permission slip from doctor.***
   __ The student does not require an emergency inhaler at school

4. Diabetes:
   __ The student will check his/her glucose level at the following times: _____/_____/_____
   __ The student will have _____ insulin at school.
   __ The student will have an insulin pump at school.
   __ The student will have a glucagon kept in the office at school if needed for an emergency.
   __ The student will have ketone strips at school.
   __ The student will need to be allowed to have snack times at: _____/_____
   __ The parent will provide snacks/juice for the office and bus to be given to the student if needed.
   Endocrinologist's Name: _____ Phone: _____

5. Seizures:
   __ The student will have Diastat to be kept in the office at school if needed for an emergency.
   __ The student does not require Diastat to be kept at school.
   Neurologist's Name: _____ Phone: _____

6. Emotional or behavioral problems? Please Explain:
   _____
   _____

7. Any hospitalization/surgery/major illness/major accident or injury? Please explain:
   _____
   _____

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I hereby give consent for South Dearborn Community School Corporation to verify dates of medical appointments as needed.

I hereby give consent for the school nurse and/or school personnel to administer to my child the following as deemed necessary to be in the best interest of my child.

1. Give minor treatment.
2. Obtain services of a physician or hospital care in case of emergency.

Doctor's Name: _____ Phone #: _____

_____ _____
(Parent Signature) (Date)

***Please note that <u>all medications</u> sent in to the school require a permission slip and must be in the original container. All prescription medications must be brought to school by the parent. Only non-prescription medications may be transported by the student.***