CONFIDENTIAL

Academy District 20 MEDICAL INFORMATION AND RELEASE FORM

Student Name _____ Birth Date_____

HEALTH QUESTIONNAIRE

Does your child have a medical diagnosis of which the school needs to be aware? YES NO

If yes, please list _____

Does your child take any medication on a regular basis or under certain conditions (as needed)? YES NO

If yes, please list medication name, dosage, frequency, purpose (please print information below)

Is your child on a Health Care Plan? YES NO Is your child on a 504 Plan? YES NO

Does your child have asthma? YES NO

If yes, is your child authorized to self-carry an asthma inhaler? YES NO

Does your child have a seizure disorder? YES NO Does your child have diabetes? YES NO

Does your child have a diagnosed life threatening allergy? YES NO If yes, is your child authorized to self-carry an epi-pen? YES NO

Does your child have any food restrictions/sensitivities? YES NO

If yes, please list _____

Please describe type of reaction that could occur with accidental ingestion of substance listed above and plan of action for school personnel.

Please provide any other information that you would like us to be aware of regarding the health, safety, and welfare of your son/daughter, including any physical limitations, drug allergies or environmental sensitivities severe enough to cause a reaction.

To the best of my knowledge, my son/ daughter has no illness, communicable disease, or physical disability that will interfere with his/her participation in this activity.

In case of an accident or other emergency, I authorize Academy District 20 staff to call 911, authorize medical care for this student at the nearest health facility, and to release the medical information disclosed on this form. I understand that the school nurse is responsible for the student's health care needs only during normal school hours.

Parent/Guardian Signature _____

Printed Name _____ Date _____

Student Signature _____

Printed Name _____