WATERTOWN SCHOOL DISTRICT #14-4
ANNUAL STUDENT HEALTH UPDATE

Please return to the School Office – Thank you!

School_____Grade/Teacher:_____

Student Name:_____
(Last) (First) (Full Middle Name)

List all medications your child is currently taking. (Contact your school nurse if any medication needs to be given at school.)

Morning: _____

Noon :_____

Evening: _____

Bedtime:_____

As needed:_____

If you check yes to any of the conditions listed below, pleases contact the school nurse to complete the appropriate paperwork. Forms must be obtained from the school office.

Medical History: (Please check all that apply and describe)

- ☐ Life Threatening/Severe Allergies: _____ Epi Pen? _____
- ☐ Bee/Wasp sting allergy: _____ Epi Pen? _____
- ☐ Food allergies: _____ Epi Pen? _____
- ☐ Seizure disorder: _____
- ☐ Diabetes: _____
- ☐ Asthma: _____
- ☐ Heart disorders: _____
- ☐ Blood disorders: _____
- ☐ ADD/ADHD/Psychological Disorder:_____
- ☐ Skin disorders: _____
- ☐ Migrane headaches: _____
- ☐ Other: _____

Does your child have any illnesses or disorders not listed above? Yes / No
If yes, please explain:
_____

Complete other side.....

Does your child wear glasses or contacts? Yes / No

In the event services of a physician appear necessary, whom would you prefer the school attempt to contact?

a. Physician or Clinic _____Phone_____

b. Second Choice_____Phone_____

Please indicate by checking that you read, understand and give permission for the following information:

_____In the event physicians, other persons named on this card or parents cannot be contacted, the school officials are hereby authorized to take whatever action is deemed necessary in their judgment, for the health of aforesaid child. As parent or guardian, I assume the responsibility for the payment of ambulance, physician, or hospital fees. I give permission to medical personnel to provide emergency health care.

_____This confidential information may be shared with staff and contracted service providers on a need to know basis. This can help the staff understand any special needs of your child and allows for the best educational plan possible.

_____The administering medication procedure below covers all prescriptions and other drugs. By checking this area and signing below, over the counter analgesics (Tylenol, Motrin, etc...), throat lozenges, or antacids, may be given at the discretion of the school nurse or trained designee.

_____The administering of an epinephrine auto-injector (Epi-pen) by a school nurse or designated school personnel, who believes a student is experiencing a severe allergic reaction, during school hours, regardless of whether a student has a prescription for an epinephrine auto-injector (Epi-pen) or has been diagnosed with an allergy. The administration of epinephrine auto-injector (Epi-pen) is in accordance with the provisions of South Dakota House Bill 1167. (This is not intended to replace specific orders or parent provided individual medications.)

Administering Medications to Students:

Students will not be permitted to take prescription medications while at school unless it is given to them by the school nurse or other trained personnel acting under the specific request of the parent or guardian. When such a request is made by a parent or guardian, a full release from the responsibilities pertaining to the administration and consequences of such medications must be presented to the school by the student's parent or guardian. (Parent Medication Request form is available in the school office.)

Please sign and date:

Signature of Parent or Guardian_____Date_____

Phone number (Cell/home): _____ (Work): _____