

**PLATTE CANYON SCHOOL DISTRICT
HEALTH AND EMERGENCY INFORMATION
2010-2011**

To be completed annually and turned in with all other registration materials

Student Name: _____ Today's Date _____
 School _____ Grade _____ Sex _____ Birth Date _____

Health Care Provider/Insurance Information:

Doctor's Name _____ Phone _____
 Dentist's Name _____ Phone _____
 Hospital Preference _____

Type of Insurance: Private Medicaid CHP+ No Insurance

If your family does not have insurance, please call **Park County Public Health Dept. at 303 -816-5936** for information on obtaining low cost health insurance for your children.

Health Information:	PAST	PRESENT	If YES, diagnosis? Please explain:
Autism	_____	_____	_____
Asthma/Respiratory Difficulties	_____	_____	_____
ADHD or ADD	_____	_____	_____
Allergies to _____	_____	_____	_____
Please describe type of reaction:	_____	_____	_____
Bladder/Kidney Problems	_____	_____	_____
Bowel Problems (constipation, diarrhea, colostomy, etc.)	_____	_____	_____
Blood Disorders	_____	_____	_____
Cancer	_____	_____	_____
Diabetes	_____	_____	_____
Eating Disorder	_____	_____	_____
Frequent Headaches	_____	_____	_____
Frequent Ear Infections	_____	_____	_____
Frequent Throat Infections	_____	_____	_____
Genetic Condition	_____	_____	_____
Head Injury	_____	_____	_____
Hearing Loss/Hearing Aids	_____	_____	_____
Heart Problems	_____	_____	_____
Hospitalization/Surgery	_____	_____	_____
Neurological Disorder (spina bifida, muscular dystrophy, tremors, etc.)	_____	_____	_____
Physical Disability (bone, joint, arthritis, muscle problems, cerebral palsy, etc.)	_____	_____	_____
Psychiatric Disorder Under Dr's care?	_____	_____	_____
Seizure Disorder	_____	_____	_____
Serious Accidents, Illnesses, Injury	_____	_____	_____
Shunts	_____	_____	_____
Skin problems	_____	_____	_____
Stomach/Digestive Problems	_____	_____	_____
Vision Problems (incl. glasses or contacts)	_____	_____	_____
Other: _____	_____	_____	_____

Health Concerns:

Have there been any concerns and/or changes in your child's health over the last year? YES/ NO (circle one) YES, please explain: _____

Restrictions :

Has the doctor restricted your child's activities for medical reasons? YES NO (circle one)

If YES, please describe: _____

NOTE: A physician's note is required to excuse your child from physical education classes.

Medications/Medical Procedures:

1. Does your child require any specific medical equipment at school (i.e. wheelchair, feeding tube, nebulizer, oxygen, etc.)? YES / NO (circle one) If YES, please explain: _____

2. Has your child required any routine, long term medications in the past? YES / NO (circle one)
If YES, please explain what medications, for what condition and how long? _____

3. Does your child currently take daily medications? YES / NO (circle one) **If YES, please list (including Medication name, dosage and frequency) :** _____

4. Will your child require medication during school hours? YES / NO (circle one) **If YES, please complete medication permission form.**

PLEASE READ COMPLETELY AND CAREFULLY:

In accordance with the Colorado State Medication Guidelines, Platte Canyon School District will administer prescription and over the counter medications (including cough drops, acetaminophen, ibuprofen, cough/cold medicine etc) **with written parent and physician permission**. It is the parent/guardian's responsibility to furnish the medication. In order to assure the safety of students, ALL medications must be brought to school by a parent/guardian and must be in the original container. Prescription medications must come in the original container labeled with: child's name, name of medicine, times medicine is to be given, dosage, pharmacy name and number and physician's name and initials _____

I give permission for school personnel to apply sunscreen to exposed skin areas, petroleum jelly to lips and hand lotion as needed. Initials _____

I understand the above health information may be shared with school personnel if determined that the information provided may impact the student's educational experience and/or safety. I give permission for this information to be shared with school personnel as deemed necessary. Initials _____

I, the undersigned, authorize officials of Platte Canyon School District to contact the above named physician and/or emergency medical system when deemed necessary, in their judgement, for the health of aforementioned child. In an emergency situation, I authorize emergency medical system personnel, the above named physician and/or physician of nearest emergency medical facility to render treatment as may be deemed necessary. Reasonable efforts will be made to contact parent/guardian or emergency contacts. I will not hold Platte Canyon School District financially responsible for expenses incurred, as a result of emergency ambulance use or treatment by physician and/or emergency medical facility. Initials _____

I HAVE READ AND UNDERSTAND THE ABOVE MEDICAL RELEASE

Parent/Guardian's Signature _____

Date _____