

ST. MARY'S SCHOOL
Permission to Treat/Health Appraisal Form

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

I hereby give consent for St. Mary's School to verify dates of medical appointments as needed and for school personnel to administer to my child the following as deemed necessary to be in the best interest of my child.

- Give minor treatment.
- Obtain services of a physician or hospital care in case of emergency.
- Disclose pertinent health information to necessary staff members.

Further, I hereby give St. Mary's permission to release the name, immunization data, DOB, address, or other identifying information as applicable concerning the above child to the Indiana State Department of Health's Children and Hoosiers Immunization Registry Program (CHIRP). I understand that the information in the registry may be used to verify that my child has received proper immunizations and to inform me or my child of my child's immunization status or that an immunization is due according to recommended immunization schedules. I understand that my child's information may be available to the immunization data registry of another state, a healthcare provider or a provider's designee, a local health department, an elementary or secondary school, a child care center, the office of Medicaid policy and planning or a contractor of the office of Medicaid policy and planning, a licensed child placing agency, and a college or university. I also understand that other entities may be added to this list through amendment to I.C. 16-38-5-3.

 (Parent Signature)

 (Date)

 (Printed Name of Parent Signature)

 Child's Doctor's Name and Telephone Number

IMPORTANT: The parent or legal guardian is responsible for assuring the medication arrives safely to school in the original pharmacy labeled container.

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

- | | | |
|-------------------------------------------------------------------|--------------------------------------------------------------|-------------------------------------------------------|
| <input type="checkbox"/> Abnormal spinal curvature | <input type="checkbox"/> Diabetes (<i>see nurse</i>) | <input type="checkbox"/> Meningitis |
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Down's Syndrome | <input type="checkbox"/> Cognitive Disability |
| <input type="checkbox"/> Allergies (seasonal – <i>see below</i>) | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Allergies (food – <i>see below</i>) | <input type="checkbox"/> Eczema | <input type="checkbox"/> Nose Bleeds |
| <input type="checkbox"/> Asthma (<i>see back</i>) | <input type="checkbox"/> Glasses/contacts | <input type="checkbox"/> Orthopedic concerns |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Headaches/migraines | <input type="checkbox"/> Seizures (<i>see back</i>) |
| <input type="checkbox"/> Behavior concerns | <input type="checkbox"/> Hearing Aid/Implant | <input type="checkbox"/> Sickle Cell |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Hearing Deficit | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Cancer, Type _____ | <input type="checkbox"/> Heart Concerns | <input type="checkbox"/> Stool soiling |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Immunodeficiency Disease | <input type="checkbox"/> Multiple Birth |
| <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Inflammatory Bowel Disease | <input type="checkbox"/> Vision Concerns |
| <input type="checkbox"/> Dental Appliance/Braces | <input type="checkbox"/> Insect Allergy (<i>see below</i>) | <input type="checkbox"/> Blindness |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Kidney Concerns | <input type="checkbox"/> Color Blind |
| <input type="checkbox"/> Developmental Delay | <input type="checkbox"/> Learning Concerns | <input type="checkbox"/> Other (please list below) |

Describe other health condition: _____

 _____ (OVER) →

1. **Current Medications:** What medications are given daily at home?

What medications are needed during school?

Reason medication is prescribed? _____

2. **Allergies:** My child is allergic to: _____

3. _____ The student **does not** require an emergency allergy medication at school.

_____ The student **does** require treatment/medication which I will bring to school. Treatment for the allergy:

_____ Benadryl _____ Epi-Pen (**Care plan required**) _____ Other: _____

_____ The student will carry an emergency Epi-Pen on self – **requires a permission slip from doctor and care plan.**

4. **Asthma/Reactive Airway Disease (complete only if your child has been diagnosed with this condition):**

_____ The student **does not** require an emergency inhaler at school.

_____ The student will keep an emergency inhaler in the school office.

_____ The student will need to use a nebulizer as needed at school.

_____ The student will carry an emergency inhaler on self – **requires a permission slip from doctor.**

5. **Seizures (complete only if your child has been diagnosed with this condition):**

_____ The student **does not** require seizure medication at school.

_____ The student will have medicine to be kept in the school office if needed for an emergency. (**Care plan required**)

Neurologist's Name: _____ Phone: _____

6. Any hospitalization/surgery/major illness/major accident or injury? Emotional or behavioral problems? Please explain:
