# Fordyce School District

**Sunni Mathews, RN**
**Fordyce High School**
**100 Redbug Blvd**
**Fordyce, AR 71742**

**Cindy Wade, LPN**
**Fordyce Elementary School**
**350 Redbug Circle**
**Fordyce, AR 71742**

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## *HEALTH INFORMATION* (please answer all questions)

SCHOOL YEAR: **2018-2019**

Name: _____ ☐Gender: M ☐F Teacher: _____Grade: _____
(Last) (First) (MI)

Social Security Number: _____ Date of Birth: _____ Does your child ride a bus? YES☐NO

Address: _____

Parent/Guardian Name(s): _____Home Phone Number: _____

Father's Employer: _____ Phone: _____ Cell #: _____

Mother's Employer: _____ Phone: _____ Cell#: _____

Authorized Emergency Contact: _____Phone: _____ Relationship: _____

Authorized Emergency Contact: _____Phone: _____ Relationship: _____

Physician's Name: _____ Phone: _____

Do you have health insurance? ☐YES☐NO
Insurance Name/AR Kids/ Medicaid: _____
Policy Holder's Name: _____
Policy #/Medicaid #: _____

Does student have a ***current*** medical diagnosis of any of the following conditions? Check all that apply

☐ ASTHMA ☐ADD/ADHD ☐WEAR CONTACTS/GLASSES
☐ DIABETES ☐ BLOOD DISORDER ☐HEARING LOSS ☐ RIGHT☐LEFT ☐HEARING AID
☐HEART CONDITION ☐CEREBRAL PALSY ☐ALLERGIC TO MEDICATION (specify): _____
☐SEIZURES ☐ KIDNEY DISORDER ☐OTHER (specify): _____
☐SEVERE OR LIFE-THREATENING ALLERGY TO NUTS, LATEX, OR STINGS (specify): _____

Please list any Food and Drug Allergies your child has: _____

What medication(s) is your child currently taking **at home and/or at school**?

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**Do we have permission to take your child to the Dallas County Medical Center Emergency Room if needed? ____Yes ____No**

I acknowledge that the Fordyce School District, the Board of Directors, and School Employees shall be immune from civil liability for damages resulting from the administration of medications in accordance with this consent.

**I will notify the school of any change in address, phone number, emergency contact or my child's health status.** I understand that the above information may be released to appropriate School District employees and emergency personnel in order to facilitate health care for my child. I also understand that in the event of an emergency, EMS will treat and transport my child to the nearest hospital. The hospital and its medical staff have my authorization to provide treatment that a physician deems necessary for the well-being of my child.

**In compliance with the Family Education Rights and Privacy Act (FERPA) (20U.S.C. & 1232g; 34 CFR Part 99), I give permission for my child's personally identifiable information/student education records to be disclosed to Third Party Billing Vendor for the purpose of billing Medicaid and/or private insurance**.

**In compliance with the Family Education Right to Privacy Act (FERPA) (20 U.S.C. § 1232g; 34 CFR Part 99) I give permission for my child to participate in the School Immunization Clinic. I understand that the appropriate Arkansas Department of Health consent forms will be provided for my consideration prior to the clinic.**

Date: _____ Signature of Parent/Guardian: _____