Your son or daughter has the opportunity to participate in an education program, created to reduce risky behaviors and prevent sexually transmitted diseases.

One out of every four adolescents has a sexually transmitted disease, many are undiagnosed, and the rate of new HIV infections in youth and young adults continues to rise. We are required by law to make information available to 8th and 10th grade students about HIV/AIDS.

Please sign and return this form to the office designating only if you do not wish for your child’s participation in the class. Should you have any questions, please contact the school.

____ NO, I do not want ______________ to receive the HIV/STD instruction. (Child’s name)

X

Signature of Parent
Roster Information and Photo/Video Permission Form

Team, group, and/or individual photos/videos along with roster information is often utilized by Fairview Public Schools, representatives, and/or students. These items are utilized for projects by students or staff, school yearbook, school website and often shared with and/or requested from the State Association (OSSAA), other schools or organizations, and various media sources for various events.

Student signature

Date

Parent Signature

Date

Student Health Record

Student Name ____________________________________

Student’s Birthdate ______________________________

Parent’s Name __________________________________

Check any of the following conditions your child has, including medications that are taken at home and/or school.

___  ADD/ADHD       Kind/time of meds ______________________

___  Allergies     Kind __________________________________

___  Asthma       ** please get an asthma form from office**

___  Blood Disease or Cancer Kind _____________________

___  Kidney Disease Kind _____________________________

___  Convulsions or Seizures Kind _____________________

___  Counseling Kind _______________________________

___  Diabetes    Type ________________________________

___  Ear/Hearing Problems Devises ___________________

___  Heart Disease Kind ______________________________

___  Learning Disabilities Kind _______________________

___  Orthopedic/bone problems Kind ___________________

___  Other conditions that affect child’s ability to perform in school. Specific Instructions:

*** If student has asthma, please pick up asthma form from the FHS office. *******

Medical Treatment Permission

In the event of an emergency requiring medical attention, I hereby grant permission to a physician or other hospital personnel designated by the Fairview High School Staff to attend my son/daughter.

Student’s name

I expect EVERY EFFORT will be made to contact me in order to receive specific authorization before any treatment or hospitalization is undertaken.

Parent Signature X__________________________________

Address _________________________________________

_________________________________________________

Home Phone ______________________________________

Father’s Work Phone ______________________________

Father’s Cell Phone ________________________________

Mother’s Work Phone ______________________________

Mother’s Cell Phone _______________________________

Date _________________________