Berryville Health & Emergency Form 2017-18 Grade: _____

Last **First** **MI**

Name: _____ Date of Birth: _____

Address: _____

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

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

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

Emergency Contact: _____ Phone: _____ Relation: _____

Emergency Contact: _____ Phone: _____ Relation: _____

Siblings Name/Grade: 1. _____ 2. _____ 3. _____

Physician's name: _____ Phone: _____ MA/ArKids? Yes No

Health Insurance? Yes No

Does your child have any health conditions, allergies, surgeries or medications to take at school? If yes, please list:

Does your child have ASTHMA? _____ If yes, does he/she carry an inhaler currently? _____

Does your child have an allergy that requires an epi-pen? _____ IF YES, PLEASE SEE THE NURSE.

Please circle the medications that you allow your child to take at school, should he/she need them:

Tylenol **Motrin/Advil** **Pepto Bismol** **Tums** **Midol** **Benadryl**

Delsym (otc cough syrup) **Phenylephrine (otc decongestant)**

I will notify the school of any change of address, phone number, emergency contact or my child's health status. I understand that the above information may be released to appropriate Berryville School District employees and emergency personnel in order to facilitate health care for my child. I 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. I will not hold the Berryville School District financially responsible for the emergency care and/or transportation for said child.

I acknowledge that the Berryville 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.

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

In compliance with the Family Education Rights and 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 this is optional and that the appropriate Arkansas Department of Health consent forms will be provided for my consideration prior to the clinic.

Signature of Parent/Guardian: _____ Date: _____