PLEASANT VALLEY DISTRICT #62 HEALTH/MEDICAL FORM 2024-2025

STUDENT'S NAME: **Grade Level for 2024-25 School Year**_____

First: **Middle:** **Last:**

MEDICAL CONDITIONS	NO	YES	EXPLAIN:
Asthma (Diagnosed by a Physician)			Inhaled med: **YES** or **NO** Oral med: **YES** or **NO** **Need Asthma Action/care plan from Physician**
Diabetes			**Arrange a conference with teacher & nurse prior to school**
Seizures			**Arrange a conference with teacher & nurse prior to school**
Heart Problems			
Blood Pressure Problems			
Bone Disorder or Injury			
Blood Disorders			
Skin Problems			
Bowel Problems			**Dietary Restrictions? (Need note from Physician)**
Urinary Problems			
Frequent Headaches or Migraines			
Eye/Vision Problems			**Glasses or Contacts**
Ear/Hearing Problems			
Emotional/ Behavioral Problems			Explain: (ADHD, ADD, Anxiety, Autism)
Allergies (seasonal, insect, food, medicine, nuts)			Explain: **Need Food care plan from Physician for Food Allergies** **EPI PEN: Yes or No**
Other Health or Physical Impairments			Explain:
Serious Illness/Injury/Hospitalization			Explain:
Medicine taken at HOME			Name of medicine:
Medicine taken at SCHOOL			Name of medicine: **Need signed note from Physician to administer at School**

Physician's Name:	**Phone:**
Hospital Preference:	
Parent Signature:	**Date:**

**I give Pleasant Valley School permission to keep this information sheet on file in the medical files. I realize that my child's teachers have access to this information. In the event of an emergency where, in the judgment of school authorities, urgent medical care is indicated and I cannot be reached, I also give permission for my child to be transported by ambulance to a hospital and for a doctor or medical personnel to give emergency treatment.

Pleasant Valley School District #62
Medication Authorization Form (2024-2025)

To be completed by the student's parent/guardian:

Student's Name ___________________________________ Birth date ____________________

Teacher________________ Grade ______ Parent/Guardian Name ___________________________

Home Phone ____

Emergency Phone Numbers ____

Allergies ____

Doctor____________________________ Office location/phone #____________________________

I hereby confirm that I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so or in the event of a medical emergency, I hereby authorize the Pleasant Valley District 62 and its employees and agents, in my behalf and stead, to administer or to attempt to administer to my child (or to allow my child to self-administer, while under the supervision of the employees and agents of the school district), lawfully prescribed medication in the manner described above. I ACKNOWLEDGE THAT IT MAY BE NECESSARY FOR THE ADMINISTRATION OF MEDICATIONS TO MY CHILD TO BE PERFORMED BY AN INDIVIDUAL OTHER THAN A SCHOOL NURSE, AND SPECIFICALLY CONSENT TO SUCH PRACTICES. I further acknowledge and agree that, when the lawfully prescribed medication is so administered or attempted to be administered, I waive any claims I might have against the school district, its employees and agents arising out of the administration of said medication. In addition, I agree to hold harmless and severally, from and against any and all claims, damages, causes of action or injuries incurred or resulting from the administration or attempt at administration of said medication.

_____________________________________ _________________________

(Parent's Signature) (Date)