ST. MARY'S SCHOOL

Permission to Treat/Health Appraisal Form

Student's Name: ____ DOB: ___/___/___ Grade:_______________

(complete a separate form for each student)

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:***

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

Describe other health condition:____

____

____(OVER) →

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

   ______________________________ Dosage: __________________ Frequency: ___________________

   ______________________________ Dosage: __________________ Frequency: ___________________

   Reason medication is prescribed? ____

   What medications are needed during school?

   ______________________________ Dosage: __________________ Frequency: ___________________

   ______________________________ Dosage: __________________ Frequency: ___________________

   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 an 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:

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2020/2021