HEALTH INFORMATION (please answer all questions) SCHOOL YEAR: _____

Name: _____ M F Teacher: _____ Grade: _____
(Last) (First) (MI)

Social Security Number: _____ Date of Birth: _____ Medicaid or AR Kids #: _____

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

Does your child ride a bus? YES NO

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): _____

What medication(s) is your child currently taking? _____

Do you authorize the use of (ex. Antibiotic Ointment):

Caladryl Clear Lotion Burn gel Skin Integrity wound cleaner Liquid Bandaid Vasaline

Peppermint Cough Drop

YES NO (Please mark through any medication you may not want your child to receive)

I acknowledge that the NEMO VISTA 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: _____