Williamstown Independent Schools

Kathy Surrett, RN, BSN, School Nurse
kathy.surrett@williamstown.kyschools.us
300 Helton St., Williamstown, KY 41097
859-824-0141

Student Health Alert/Medical Release Form

This questionnaire is designed to aid school staff in recognizing any health concerns that might affect your child's safety or learning. All information on this form is kept confidential.

Student Name_____School Year:_____ Grade: _____
Male /Female Date of Birth_____
Student's Physician Name & Phone Number_____

MEDICAL:

□ MY CHILD has NO medical concerns or conditions.

MY CHILD has the following medical conditions as diagnosed by a licensed health care professional:

□Asthma (complete Asthma Action Plan) □Seizure disorder (complete Seizure Action Plan) □ Migraines
□Bleeding disorder □ADD/ADHD □ Head Injury/Concussion □Autism □Cystic Fibrosis □Sickle Cell Trait
□Diabetes (complete Diabetes Action Plan) □ Vision/Hearing Difficulty □Skin condition □ Learning disability
□Heart condition □Mental health condition (*circle*: depression, anxiety, eating disorder)
□Other condition (explain) _____
□Surgery explain: _____
Are there any other illnesses, injuries, health, behavioral or emotional condition(s) that may affect your child's performance at school or school sponsored events or functions?
Please explain:_____
_____

ALLERGIES: (Complete Allergic Reaction/Anaphylaxis Healthcare Action Packet)
□Plants □Animals □Food □Molds □Medications □ Insect venom □Other _____
□EPI-PEN prescribed (Submit Dr. order)
Please describe the allergic reaction and the treatment for **each** checked allergy:
_____
_____

MEDICATION:

Does your child take any prescribed medication? □Yes □No Name of Medication(s): _____
_____
Is medication required during the school day or on school sponsored events or functions? □Yes □ No
****If YES, Complete Medication Authorization Form and meet with the School Nurse. ****

Any medication, prescription or nonprescription, to be given at school, must be accompanied by a Physician's order.

In the event of an injury requiring medical attention, I hereby grant permission to the supervising teacher(s)or staff to attend to my child. If the injury warrants further medical attention, I expect every effort will be made to contact me to receive my specific authorization before action is taken. If efforts to contact me are unsuccessful, I grant permission for necessary medical treatment to be given. I understand that I will be responsible for any medical/doctor fee.
I also acknowledge that I am giving permission for the School Nurse at Williamstown Independent Schools to contact my child's doctor and discuss medical information about my child.

_____ _____ _____ _____
Parent/Guardian (sign) *phone number(s)* *Date*

_____ _____ _____
Emergency contact /Relation/phone number(s)

_____
Emergency contact/Relation/phone number(s)