Saltillo High School Student Medical Form (Nurse's Form)

Grade _____

Student's Name _____ _____ _____
Last Name First Name Middle Name

Circle One: Male or Female **DOB:** _____ **Student's Cell Phone Number:**_____

Mother/Guardian: _____
Home Phone: _____
Cell Phone: _____
Employer Phone: _____

Father/Guardian: _____
Home Phone: _____
Cell Phone: _____
Employer Phone: _____

List two people who will pick your child up if you can not be reached:
Name: _____ **Relationship:** _____ **Phone:** _____
Name: _____ **Relationship:** _____ **Phone:** _____

Other Children in Household:
Name: _____ **School:** _____ **Grade:** _____
Name: _____ **School:** _____ **Grade:** _____
Name: _____ **School:** _____ **Grade:** _____

List any medications taken presently (including dosage and frequency):
1. _____ **2.** _____
3. _____ **4.** _____

List any medical or food allergies:
_____
_____

Please indicate if your child is medically covered by any of the following, including the policy name and number:
Yes ____ **No** ____ **CHIPS** _____
Yes ____ **No** ____ **Medicaid#** _____
Yes ____ **No** ____ **Health Insurance** _____

Please check yes or no to all that apply to your child:
Yes ____ **No** ____ **Eye Problems** **Comment:** _____
Yes ____ **No** ____ **Wears Glasses** **When:** _____
Yes ____ **No** ____ **Hearing Problems or Devices** **Comment:** _____

IMPORTANT - The following medical information will be released to school officials who need information to protect the health or safety of students.

Check any health conditions that your child has a medical diagnoses for:

____ **ADD/ADHD**	____ **Cystic Fibrosis**	____ **Hearing Loss**	____ **Sickle Cell**
____ **Allergies (Severe)**	____ **Diabetes**	____ **Kidney Disease or UTI**	____ **Sinus Infections**
____ **Asthma**	____ **Ear Infections**	____ **Multiple Sclerosis**	____ **Other Conditions**
____ **Cerebral Palsy**	____ **Epilepsy**	____ **Muscular Dystrophy**	

Responding to the following question will help us in the event of contact tracing due to exposure to a positive COVID-19 case:

Has your child been vaccinated for COVID-19? **Yes**_____ **No**_____

Comments:
_____
_____

LCSD Policy states that no over the counter medications will be given to any student. Refer to the LCS Handbook.

I hereby give consent for my child to have health screenings, first aid, and/or any emergency intervention needed at school.

Parent/Guardian Signature: _____ **Date:** _____