Little Rines Early Childhood - Parental Health Consent Form

(Please Print)

Name of Student (Last, First, Middle):	**Sex (Circle One):** Male or Female	**Phone Number:**
Address: **P.O. Box #**	**Child's Place of Birth:**	*West Bend Mallard CSD* *Little Rines Preschool* *(515)-887-7821*
City, State, & Zip Code:	**Date of Birth:** _____/_____/_____ (Month/Day/Year)	**Social Security #:** — — — - — — - — — — —

Glasses	Does your child wear glasses/contacts? (Circle One) Yes No Date of last eye appointment: _____

Hearing	Does your child have a hearing disorder? (Circle One) Yes No
	Does your child use any hearing devices? (Circle One) Yes No

Medical Concerns	Please list any other health concerns the school should know about your child:

Medication Information	Does your child take any daily/routine medications? (Circle One) Yes No		
	Name of Medication:	***Time and frequency:***	***Reason for Medication:***
	1.		
	2.		
	3.		
	4.		

Allergies	***Please list any allergies your child has to …***
	Medications:
	Food:
	Other:
	Will an Epi-Pen be required at school by the parent? (Circle One) Yes No
	Please describe any allergic reaction for listed above, including signs/symptoms to look out for:

Insurance Information	***Please circle what type of insurance you have for your child:*** Private Insurance Title 19 HAWK-I No Insurance If Private, Name of Insurance: _____ If Medicaid, Medicaid #: _____

Name of Primary Care Provider/Physician: _____

Provider/Physician Address: _____

Provider/Physician Phone Number: _____

Name of Primary Dentist: _____

Primary Dentist Address: _____

Primary Dentist Phone Number: _____

(Please complete other side)

Over-the-Counter Authorization

The following list of medications are available at school for the SECRETARY to give to your child, with written permission.

PLEASE MARK THE MEDICATIONS YOU WOULD LIKE YOUR CHILD TO RECEIVE:

☐ Acetaminophen (Tylenol) ☐ Ibuprofen (Advil/Motrin) ☐ Diphenhydramine (Benadryl) ☐ Antacids (Tums) *****A total of 10 doses will be given per year unless there is an order form a physician/provider*****	☐ None

I give permission for the teachers to administer the above medications as needed for my child.

Parent/Guardian Signature: _____ Date Signed: _____

Parent/Guardian Information

1) Name:	Home Phone:	Work Phone:	Lives with child: ☐ Yes ☐ No
Address:	Cell Phone:	Email Address:	
2) Name:	Home Phone:	Work Phone:	Lives with child: ☐ Yes ☐ No
Address:	Cell Phone:	Email Address:	

People to Contact if Parent or Guardian is Unavailable

1) Name:	Home Phone:
Relationship with child:	Cell Phone:
2) Name	Home Phone:
Relationship with child:	Cell Phone:

Immunizations

Please list off any immunizations your child has had in the past year:

NEED VERIFICATION ATTACHED FROM PROVIDER OR CLINIC

Given by: (Circle One) Dr. Office/Clinic ER/Hospital Public Health

Health Record Authorization

Please list names and 'relationship to child' for people who can access your child's health records.

Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____

Emergency Release

I give permission to the appropriate personnel of ***LITTLE RINES PRESCHOOL*** to secure and authorize emergency medical care and treatment for my child, that in their judgement is necessary in the best interest of my child while under their supervision. I also agree to assume and pay for the fees for the emergency medical treatment as authorized in this statement. I under that this health information sheet is confidential but the information will be shared with other ***LITTLE RINES PRESCHOOL*** personnel as needed.

Parent/Guardian Signature: _____ Date Signed: _____