CHECK HERE IF INFORMATION HAS CHANGED SINCE LAST YEAR _____

SUNMAN-DEARBORN COMMUNITY SCHOOLS
STUDENT AND HEALTH INFORMATION
2015-2016

GRADE _____

TEACHER _____

Student: _____ ____ ____ _____ _____
(Last Name) (First Name) (Middle Name) M/F Age Date of Birth Grade

Mailing Address: _____
(Street/ PO Box) (City) (Zip Code)

(If you have a P.O. Box, list your 9-1-1 Address) _____

County: _____ Home Phone: _____

Student rides Bus # _____ AM (Circle) From: Home Daycare or Sitter Drives Other_____

Student rides Bus # _____ PM (Circle) To: Home Daycare or Sitter Drives Other _____

Is a parent(s)/guardian(s) currently active military personnel? ____ No ____ Yes

Student Lives With (circle): Mother Stepmother Other (relationship) _____

Name: _____ Employer: _____ Shift: _____

Work Phone: _____ Cell: _____ Pager: _____

Student Lives With (circle): Father Stepfather Other (relationship) _____

Name: _____ Employer: _____ Shift: _____

Work Phone: _____ Cell: _____ Pager: _____

If student does not live with both parents, are there custodial restrictions on non-custodial parent that the school should be aware of? YES _____ NO _____
Who has custody? _____ (**custody papers are required on file)**

Explain (or see Principal/Asst. Principal) _____

Name of Non-Custodial Parent: _____ Phone: _____

If the parent ***WITH*** custody cannot be reached in an emergency, can the school contact the parent ***WITHOUT*** custody?
Yes _____ No _____
Can the parent ***WITHOUT*** custody pick-up the student from school? Yes _____ No _____

List two neighbors or nearby relatives who will assume temporary care of your child if you cannot be reached.

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

List siblings enrolled in this school corporation below:

Name: _____ School: _____

Name: _____ School: _____

Signature of Parent/Guardian: _____ Date: _____

CONTINUED ON BACK

Medical History and Consents:

The information on this form can be shared with other corporation personnel as necessary for the well being of this student. Consents granted on this form are valid for only this school year and a new form is required each year.

Parent Signature: _____ Date: _____

PLEASE CIRCLE AND FILL IN THE BLANKS TO ALL THAT APPLY BELOW:

ADD/ADHD Medication: _____ Dose: _____ Times Given: _____
Severe Allergic Reaction (**Requiring Epi-pen & MD orders**): TO WHAT? _____
Mild or Moderate Allergic Reaction: TO WHAT? _____
Is student allergic to any medications? WHAT MEDICATION? _____
Seasonal Allergies: TO WHAT? _____
Severe Asthma (requiring inhaler/nebulizer & MD orders). List Inhaler/nebulizer used _____
Mild Asthma (no inhaler needed)
Diabetes (insulin dependent requires MD orders): Pump: Yes No Needs: (Circle) Insulin AM/PM Snacks
Epilepsy (Seizures): (Circle) Absence Tonic/Clonic Partial Date last seizure _____
Seizure Medications: _____
Hearing Loss: (Circle) Right Left Hearing Aid Needs Preferred Seating
Heart Condition: Specify _____
Headaches: (Circle) Frequent MD Diagnosed Migraines (needs MD orders)
Irritable Bowel: Explain _____
Menstrual Problems: Explain _____
Orthopedic Limits: Explain _____PE limits _____
Restricted Physical Activities: _____
Psychological DX: _____
Scoliosis: _____
Urinary Problems: _____
Vision: (Circle) Glasses Contacts Other
Other: _____
List all prescription medications this student is currently taking: _____
_____

Regulations established by the Indiana State Board of Health require that schools have parental permission to administer non-aspirin pain reliever, antacids, sore throat lozenges, Orajel, Aloe and Calamine Lotion for minor discomfort *on an infrequent basis***.**

I hereby give permission for _____ to receive non-aspirin pain reliever (and the over-the-counter products listed above) during school hours for minor discomfort.
(Student Name)

Signature of Parent/Guardian: _____ Date: _____

In case of an accident or serious illness, I request the school to contact me. If the school is unable to reach me, I hereby authorize the school to call the physician below and to follow his instructions and/or call the life squad. **Depending on the emergency the life squad will make the decision of where to transport your child according to their mandates.** If you would like to request a hospital, please circle one of the following. Margaret Mary Dearborn Co. Mercy Health-Harrison Medical Center

Physician's Name: _____ Phone: _____
(Number must be provided)
Dentist's Name: _____ Phone: _____

PLEASE NOTIFY SCHOOL IF ANY OF THE ABOVE INFORMATION CHANGES