## **School:** **SES** **NES** **DMS** **DWS** **DCHS Grade\_\_\_\_\_\_ Homeroom Teacher\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Student Name: Last\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth:\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ Sex:\_\_\_\_\_\_ State or Country of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Main Language Spoken\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State:\_\_\_\_\_\_\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_

Name of Mother/Legal Guardian:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work/Cell:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Father/Legal Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work/Cell:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Student\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the office have legal/custody papers on file for this student? Y\_\_\_\_\_\_ N\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| CONDITION | YES | COMMENTS | IF THE STUDENTS CONDITION REQUIRES TREATMENT OR MEDICATION DURING SCHOOL HOURS, PLEASE DESCRIBE. |
| Allergies (food, insects, drugs latex) |  |  |  |
| Asthma or Breathing Problems |  |  |  |
| Attention-Deficit  Hyperactivity Disorder |  |  |  |
| Kidney or Bladder Condition |  |  |  |
| Bowel Problems |  |  |  |
| Cerebral Palsy/CF/Other Diagnosis |  |  |  |
| Diabetes |  |  |  |
| History of Head or Spinal Injury |  |  |  |
| Hearing Problems or Deafness |  |  |  |
| Heart Problems/Bleeding Disorders/Blood Disorder |  |  |  |
| Seizure Disorder |  |  |  |

Describe any other important health-related information about your child (for example; feeding tube, oxygen support, hearing aid, etc.)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List all prescriptions, over-the-counter, and other medications your child takes regularly

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please provide the following:

|  |  |  |  |
| --- | --- | --- | --- |
|  | NAME | PHONE | DATE OF LAST APPOINTMENT |
| Pediatrician/Primary Care Physician |  |  |  |
| Specialist |  |  |  |
| Dentist |  |  |  |
| Case Worker (if applicable) |  |  |  |

Student Health Insurance: None\_\_\_\_\_ Medicaid\_\_\_\_\_ TennCare\_\_\_\_\_ Private/Commercial/Employer Sponsored\_\_\_\_\_

# **Please read the following carefully and if in agreement sign below. If your child has a chronic medical condition, please contact the school nurse.**

I\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(do\_\_\_\_\_) (do not\_\_\_\_\_) authorize my child’s health care provider and designated provider of health care in the school setting to discuss my child’s health concerns and/or exchange information pertaining to this form. (You may withdraw your authorization at any time by contacting your school.)

I understand that it is my responsibility to notify the school health services as soon as possible if I feel my child’s health condition requires nursing procedures. I understand that if my child’s health condition requires emergency management (i.e. Epipen etc.) it is my responsibility to contact school health services as soon as possible for more information on an individual health plan for my child. I understand that if my child requires medication during the school day, it is my responsibility to bring the medication to the school, complete the parental permission form, and comply with the school’s medication policy.

Parent/Guardian Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Escuela: SES( ) NES( ) DMS( ) DWS( ) DCHS( ) Maestro Asesor\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Nombre del Estudiante:Apellido \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Primero:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Segundo:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

La fecha de Nacimiento:\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Sexo:\_\_\_\_\_ Estado o País de Nacimiento:\_\_\_\_\_\_\_\_\_\_\_ Idioma Principal que Habla\_\_\_\_\_\_\_\_\_\_\_

Dirección del Estudiante:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Ciudad:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Estado:\_\_\_\_\_\_\_\_\_\_\_\_ CP:\_\_\_\_\_\_\_

Nombre de la Madre / Tutor:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Teléfono:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Trabajo / Celular:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Nombre del Padre / Tutor:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Teléfono:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Trabajo / Celular:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contacto de Emergencia:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relación con el Estudiante\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Teléfono\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

¿Tiene la oficina papeles legales / Custodia en el archivo para éste estudiante? Si\_\_\_\_\_\_ No\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| CONDICIÓN | Sí | COMENTARIOS | Si la condición del estudiantes requiere tratamiento o medicamento durante horas escolares, por favor describir. |
| Alergias (comida, insectos, látex o medicamentos) |  |  |  |
| Asma o problemas de respiración |  |  |  |
| Desorden de Hiperactividad |  |  |  |
| Condición de Riñón o Vejiga |  |  |  |
| Problemas del Intestino |  |  |  |
| Parálisis Cerebral/ Parálisis Cerebral/otros diagnósticos |  |  |  |
| Diabetes |  |  |  |
| Historia de lesión de la Cabeza o Vertebral |  |  |  |
| Problemas Auditivos o Sordera |  |  |  |
| Problemas del Corazón/Problemas de sangrado/Problemas de la sangre |  |  |  |
| Desorden Epileptico |  |  |  |

Describir cualquier otra información importante de salud sobre su niño (por ejemplo; alimentción de tubo, oxígeno, ayuda auditiva, etc.)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Enliste todo medicamento, recetado o sobre el mostrador que su niño toma con regularidad.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Por favor proporcionar lo siguiente:

|  |  |  |  |
| --- | --- | --- | --- |
|  | NOMBRE | TELÉFONO | FECHA DE LA ÚLTIMA CITA |
| Pediatra / Médico de Cabecera |  |  |  |
| Especialista |  |  |  |
| Dentista |  |  |  |
| Asistente Social (si aplica) |  |  |  |

Seguro Médico del estudiante: ninguno\_\_\_\_\_ Medicaid\_\_\_\_\_ TennCare\_\_\_\_\_Privado /Commercial/ Patrocinardo por el Empleo\_\_\_\_

# Por favor lea lo siguiente cuidadosamente y firme el acuerdo abajo. Si su niño tiene un estado de salud crónico, por favor contácte a la enfermera escolar.

Yo\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(doy\_\_\_\_\_) (no doy\_\_\_\_\_) a los provedores asignados de salud en la escuela de mi hijo la autorización de discutir los probklemas de salud de mi hiho y/o intercambiar información en relación con esta forma. (Usted puede retractarse de- su autorización en cualquier momento contactandose a la escuela.)

Tengo entendido que es mi responsabilidad de notificar a los servicios de la escuela lo antes posible si siento que la condición de salud de mi niño requiere los servicios de enfermería. Comprendo que si la condición de salud de mi niño requiere la dirección de emergencia (i.e.. Epidermica etc..) Es mi responsabilidad de contactar a los servicios de salud de la escuela lo antes posible para más información sobre un plan de salud individual para mi niño. Tengo entendido que si mi niño requiere el tratamiento durante el día escolar, es mi responsabilidad de traer el tratamiento a la escuela, llenar el formulario de permiso, y obedecer la política de tratamiento de la escuela.

Firma del Padre / Tutor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fecha\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_