SISTERS SCHOOL DISTRICT STUDENT HEALTH CONCERNS 2026-2027

Re:_____ _____/_____/_____

(student name/grade) (birthdate)

Parent/Guardian:_____ Daytime Phone Number:_____

PRINT

Does your student have any current medical concerns: □ Yes □ No

My child has the following medical concern(s) (please check all that apply)

□ ADD/ADHD
□ Asthma
□ Bleeding Disorder (specify)_____
□ Cardiac Condition (specify)_____
□ Diabetes Type 1 _____ Type 2 _____
□ Eating Disorder (specify)_____
□ Eye/Ear Problem (specify)_____
□ Food Allergies (specify) _____
□ Insect Allergy (specify) _____
□ Medication Allergy (specify) _____
□ Muscle/Bone/Joint Problem (specify) _____
□ Recurrent Headaches _____
□ Seasonal/Environmental Allergies _____
□ Seizures (specify what kind) _____
□ Surgery (specify and indicate date) _____
□ COVID-19 positive date_____Lasting Symptoms □ Yes □ No
□ Traumatic (Acquired) Brain Injury/Concussion Date_____
□ Other (specify) _____
□ My child is taking medication at home (prescription, over-the-counter, daily or as needed) (specify):

_____

□ My child will need medication during school hours: Inhaler/Epi-Pen/Other (specify):

_____

Nurse's Notes

(Students who require an Epi-Pen will bring dose to office and have an emergency protocol on file)

If your child ***does*** have a medical concern, the nurse will contact you to obtain more information and to plan for the upcoming school year.

- ***If any changes occur or a new condition is diagnosed during the school year, I, the parent/guardian, will notify the school nurse of the new status by providing a new student health concern form. Overnight trips might require additional forms.***
- In the case of an emergency, I ***give / do not give*** permission for my child to be transported to the nearest facility and for their staff to provide the necessary treatment until I arrive.
- Insurance Provider_____

Parent/Guardian Signature:_____Date:_____

Release of Confidential Information: For your child's safety and well-being while at school and on field trips, it may be beneficial for appropriate school personnel to be informed of any medical conditions included on this medical authorization form. Please be assured the staff will keep this information confidential. If you do not want medical information shared, please indicate to the school in writing on this form.

RETURN TO OFFICE