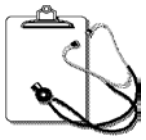

WAYNESVILLE R-VI SCHOOLS

Student Medical Form

Please notify the nurse immediately regarding any change in the following information

Student _____ Birth Date _____ Sex ___ Grade _____ Teacher _____
Address _____ Home Phone _____
Father's Name _____ Work Phone _____ Cell Phone _____
Mother's Name _____ Work Phone _____ Cell Phone _____
Emergency Contact _____ Phone _____
Doctor _____ Phone _____
Dentist _____ Phone _____

Date of last physical _____

Allergies: Medication _____
Food _____
(If a special lunch is requested, a Dietary Request form signed by the doctor and parent must be on file *with the school nurse)*
Seasonal _____
Severe Bee/Insect _____
Other _____

Prescribed Daily Medications:

Medication Name _____ Dosage _____ Time _____ Reason for medication _____
Medication Name _____ Dosage _____ Time _____ Reason for medication _____

A medical authorization form must be on file in the nurse's office if medications are to be dispensed. This form must be signed by the parent for over the counter medications and signed by the parent and doctor for prescription medications before any medication can be given by the school. A new form must be presented to the school each new school year. Medications must be in the original container. Students are not allowed to transport medications except when authorized by a physician.

Medical problems diagnosed within the last year _____

Please check any of the following areas of health concern applicable to your child:

❑ ADD	❑ Asthma	❑ Diabetes	❑ Heart	❑ Vision (uncorrectable)
❑ ADHD	❑ Bleeding Disorder	❑ Epilepsy (Seizures)	❑ Hearing	❑ Other _____
❑ Anemia	❑ Contact lenses (❑ soft / ❑ hard)	❑ Glasses	❑ Sickle cell anemia	

Please explain above problems in further detail: _____
_____
_____

All students will participate in regular physical education program unless a Physical Excuse Form, signed by the physician, is on record in the nurse's office at the school. The student will be placed in an Adaptive Physical Education Program if he/she is unable to participate in the regular program.

I. Check all boxes below indicating you grant permission for your child to receive the appropriate dosage for his/her age and weight of the following over the counter medications for pain, cough, sore throat, skin irritations, tooth pain, or fever of 100 degrees or above:

❑ Antibiotic ointment (Neosporin, Bacitracin)
❑ Chloroseptic Spray
❑ Cough drops
❑ Tums
❑ Orajel
❑ Motrin or its generic form per manufacturer's instructions
❑ Tylenol or generic form per manufacturer's instructions

II. In the event of a medical emergency, as determined by the school nurse or other responsible staff member, it is the policy of the Waynesville R-VI School District to dial 911 immediately to obtain emergency medical services and/or transport to the nearest approved medical facility. The school officials are hereby authorized to take whatever action is deemed necessary in their judgment, for the health of the aforesaid child. I will not hold the school district financially responsible for the emergency care and/or transportation for said child.

If refused, please state in writing the action to be taken in the event of an emergency: _____
_____

Signature: _____ Date _____