

Good Shepherd Christian Academy Permission to Treat/Health Appraisal Form

Student's Name: _____ DOB: ___/___/___ Grade: _____
(complete a separate form for each student)

I hereby give consent for Good Shepherd Christian Academy to verify dates of medical appointments as needed and for school personnel to administer to my child the following as deemed necessary to be in the best interest of my child.

- Give minor treatment.
- Obtain the services of a physician or hospital care in case of emergency.
- Disclose pertinent health information to necessary staff members.

(Parent Signature)

(Date)

(Printed Name of Parent Signature)

Child's Doctor's Name and Telephone Number

Child's Dentist's Name and Telephone Number

Health Conditions- please check any that this child has had:

- | | | |
|---|--|---|
| <input type="checkbox"/> Abnormal spinal curvature | <input type="checkbox"/> Diabetes (<i>see nurse</i>) | <input type="checkbox"/> Meningitis |
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Down's Syndrome | <input type="checkbox"/> Cognitive Disability |
| <input type="checkbox"/> Allergies (seasonal – <i>see below</i>) | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Allergies (food – <i>see below</i>) | <input type="checkbox"/> Eczema | <input type="checkbox"/> Nose Bleeds |
| <input type="checkbox"/> Asthma (<i>see back</i>) | <input type="checkbox"/> Glasses/contacts | <input type="checkbox"/> Orthopedic concerns |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Headaches/migraines | <input type="checkbox"/> Seizures (<i>see back</i>) |
| <input type="checkbox"/> Behavior concerns | <input type="checkbox"/> Hearing Aid/Implant | <input type="checkbox"/> Sickle Cell |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Hearing Deficit | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Cancer, Type _____ | <input type="checkbox"/> Heart Concerns | <input type="checkbox"/> Stool soiling |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Immunodeficiency Disease | <input type="checkbox"/> Multiple Birth |
| <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Inflammatory Bowel Disease | <input type="checkbox"/> Vision Concerns |
| <input type="checkbox"/> Dental Appliance/Braces | <input type="checkbox"/> Insect Allergy (<i>see below</i>) | <input type="checkbox"/> Blindness |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Kidney Concerns | <input type="checkbox"/> Color Blind |
| <input type="checkbox"/> Developmental Delay | <input type="checkbox"/> Learning Concerns | <input type="checkbox"/> Other (please list below) |

Describe other health condition:

Current Medications: What medications are given daily at home?

_____ Dosage: _____ Frequency: _____

_____ Dosage: _____ Frequency: _____

Reason medication is prescribed? _____

What medications are needed during school? **IMPORTANT: The parent or legal guardian is responsible for assuring the medication arrives safely to school in the original pharmacy labeled container.**

_____ Dosage: _____ Frequency: _____

_____ Dosage: _____ Frequency: _____

Reason medication is prescribed? _____

1. **Allergies:** My child is allergic to: _____

2. _____ The student **does not** require an emergency allergy medication at school.

_____ The student **does** require treatment/medication which I will bring to school. Treatment for the allergy:

_____ Benadryl _____ Epi-Pen (**Care plan required**) _____ Other: _____

_____ The student will carry an emergency Epi-Pen on self – **requires a permission slip from the doctor and care plan.**

1. **Asthma/Reactive Airway Disease (complete only if your child has been diagnosed with this condition):**

_____ The student **does not** require an emergency inhaler at school.

_____ The student will keep an emergency inhaler in the school office.

_____ The student will need to use a nebulizer as needed at school.

_____ The student will carry an emergency inhaler on self – **requires a permission slip from the doctor.**

1. **Seizures (complete only if your child has been diagnosed with this condition):**

_____ The student **does not** require seizure medication at school.

_____ The student will have medicine to be kept in the school office if needed for an emergency. (**Care plan required**)

Neurologist's Name: _____ Phone: _____

1. Any hospitalization/surgery/major illness/major accident or injury? Emotional or behavioral problems? Please explain:

