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:***

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

Describe other health condition:

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____
____

(OVER) →

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 themself – and ***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:

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2024/2025