Hamilton Community Schools
903 South Wayne Street- Hamilton, IN 46742- Ph. 260.488.2101

Annual Health Update

Student Name: _____ Grade/Teacher: _____
Parent/Guardian: _____ Telephone: _____
Family Doctor: _____ Telephone: _____

*Please check all health conditions below that affect your child:

- o ADD/ADHD
- o Seasonal Allergies
- o Asthma
- o Bee sting/ Insect allergy
- o Food Allergy
- o Diabetes
- o Cystic Fibrosis
- o Gastrointestinal Disorder
- o Hearing Loss
- o Visual Impairment
- o Heart Condition
- o Kidney Disorder
- o Malignancy/Cancer, Type: _____
- o Neurological Disorder
- o Seizures
  Type: _____
- o Sickle Cell Anemia
- o Hemophilia/ Bleeding Disorder
- o Other: _____
  _____
  _____
- o List any drug allergies: _____
  _____
  _____

Explain any treatments and considerations the school nurse and necessary staff need to be aware of regarding your child's diagnosis:

_____
_____
_____

List all medications including administration time and dosage:

_____
_____
_____

Past surgical History:

_____
_____
_____

** By signing this form you agree the above information will be shared only with necessary staff and emergency care personnel directly involved in the care, safety, and well- being of your child**

_____ _____
Parent/Guardian Signature Date

Hamilton Community Schools
Emergency Medical Authorization/Permit

Whenever my child is involved in a school activity and I am unavailable or otherwise unable to provide authorization directly, I grant the school principal or his/her designee the authority to act for me and to provide any required consents and authorization for the delivery of emergency medical care, diagnosis, and treatment. including surgical intervention, if necessary, on behalf of my minor child listed below and do all other necessary things as I might or could do to provide for the child's health and safety, if I were present.

*This authorization is valid for the current school year or until such time as I withdraw the authorization.

Authorized: _____ Date: _____
(Custodial Parent/ Guardian)

Student's Name: _____ Date of Birth: _____

Home Address: _____ Grade/ Teacher: _____

Custodial Parent/Guardian: _____

Mother's Name: _____ Cell/Home Phone: _____

Mother's Work: _____ Work Phone: _____

Father's Name: _____ Cell/Home Phone: _____

Father's Work: _____ Work Phone: _____

- Since the care and treatment of the student is the primary responsibility of the parent, every effort will be made to contact the parent's first. Please list Parent Substitutes who can be contacted regarding student's care in the event a parent cannot be reached. ***Please Note: Only those listed below will be permitted to pick up your child in case of an illness or emergency.***

Sub's Name: _____ Relationship: _____ Phone: _____

Sub's Name: _____ Relationship: _____ Phone: _____

Sub's Name: _____ Relationship: _____ Phone: _____

- List anyone who is NOT PERMITTED to pick up your child from school:

Name: _____

Name: _____

Important Medical Information:

Hospital Preferred: _____

Doctor Preferred: _____ Telephone: _____

Dentist Preferred: _____ Telephone: _____

Insurance Company: _____ I.D Number: _____

IF THE SCHOOL REPRESENTATIVES ARE UNABLE TO CONTACT PARENTS IN THE EVENT OF AN EMERGENCY, THE SCHOOL WILL HAVE YOUR CHILD TRANSPORTED BY AMBULANCE.

Parent/Guardian Signature: _____ Date: _____