Derby PUBLIC SCHOOLS

Student's Name: _____ School: _____

Complete the following checklist by indicating any of the following student conditions

This child has no health needs.

Allergies

	Environment	Please list:
	Food	Please list:
	Insect/Bees	Please list:
	Medications	Please list:
	Other	Please list:

Health Conditions

ADD/ADHD	Bone/Joint/Muscular Disorder	Migraines/Headaches
Anemia	Cardiac	Obsessive Compulsive Disorder
Anxiety	Convulsion/Epilepsy	Oppositional Defiant Disorder
Arthritis	Depression	Reflux (gastroesophageal)
Asthma Mild Asthma Moderate Asthma Severe	Diabetes	Seizures
Autism/Aspergers	Digestive/Bowel Problems	Skin Disorders
Bi-Polar	Down Syndrome	Thyroid Disease
Bladder/Kidney Disorder	Eating Disorder	Tourettes (Tics)
Bleeding/Clotting Disorder	Hypoglycemia	Traumatic Brain Injury

Current Medications *Please provide information in boxes*

Med #1:	Dosage:	Condition:
Med #2:	Dosage:	Condition:
Med #3:	Dosage:	Condition:

Med #4:	Dosage:	Condition:

Vision		Hearing	
	Glasses/Contacts		Hearing Aids
	Vision Concerns		Hearing Problems

Healthcare provider information on file *Please provide information in boxes*

Physician	
Hospital	

	I acknowledge that the above information relating to the health of my child is current	Signature: Date:

Consent for Treatment of Minor Dependents

Student's Full Name: _____ Grade: _____

Parent/Guardian Name: _____

Address: _____ Phone: _____

Business Phone: _____ Emergency Phone: _____

If unable to reach responsible party for dependent child,

_____
(Name of Student)

You have my consent to call _____ at _____
(Physician's Name) *(Phone #)*

and/or send to _____ by ambulance if situation warrants.
(Hospital name)

I further give my consent to above physician and/or hospital to care for dependent child at their discretion in the best interest of the child.

_____ _____
(Date) *(Parent/Guardian Signature)*