St. Johns Lutheran School
Student Health Form

Name:		Date of Birth: / /
(Last)	*(First)*	*(Middle)*
Student's Physician:	Name: Phone Number:	
Student's Dentist:	Name: Phone Number:	
Does your child have allergies?	Yes / No	If yes, please list allergy and any medication required:
Does your child have reactions to insect bites?	Yes / No	If yes, please list reaction and any medication required:
Does your child have asthma?	Yes / No	If yes, please list medications taken as needed:
List any prescription or over-the-counter medications your child takes frequently/routinely/or during school hours:		
Does your child have special activity needs or restrictions?	Yes / No	If yes, please list:
Does your child have chronic illnesses?	Yes / No	If yes, please list:
Does your child have (circle all that apply):	Glasses Contacts Retainer Hearing Aid Dental Braces	
Does your child have any other illnesses, injuries, emotional, behavioral, or health concerns you feel the school will need to know:		
I hereby give my permission for St. Johns Lutheran School to act in an emergency situation if I cannot be reached. Parent Signature:		Date:

911 will be called in the event of an emergency.

Chronic Condition Emergency Procedure:

My child,_____, has _____, which could require emergency medication and/or care. Please discuss this procedure with your child and your physician so that you all understand and agree about what will happen in the event of an emergency. List in order the sequence of things that should be done for your child (i.e., call 911, give Epi-pen, call parents, give other medications, apply ice pack, etc.):

1._____
2._____
3._____
4._____
5._____

I request that the above procedure be followed for my child.

PARENT PERMISSION TO DISPENSE PRESCRIPTION OR OVER-THE-COUNTER DRUGS

St. Johns Lutheran School, Wykoff, MN

Student:_____ Grade_____ Date of Birth___/____/____

Date form received by the school:_____

Name of medication:_____

Reason for medication:(OPTIONAL)_____

Form of medication/treatment:

Tablet/capsule Liquid Other_____

Instructions (Schedule and dose to be given at school):_____

_____

Beginning date: ____/____/____ End date: ____/____/____

Describe the circumstances which would trigger the administration/dispensing of this medication:

_____

Are there special storage requirements? ___No ___Yes Describe: _____

_____

All medications must be in the original container with the student's name affixed to the outside of the bottle/container.

I understand that my child's homeroom teacher or Mrs. Schultz will be the primary person to dispense this medication. Any school personnel may dispense medications in their absence.

The undersigned parent for himself, his agents, successors, assigns, or representatives, hereby releases, indemnifies, holds harmless, and forever discharges St. Johns Lutheran School and its agents, successors, assigns or employees from all claims, demands, actions, causes of action or suits of whatsoever kind or nature known or unknown arising from dispensing medications as per the terms of this agreement.

I request that _____receive the above medication as indicated.

(Student's Name)

Date____/____/____Signature_____Relationship_____