CLEVELAND SCHOOL DISTRICT
HEALTH SERVICES
CHILD HEALTH RECORD

STUDENT NAME: ___________________________________ Date of birth: _____________ M__ F__ AGE_____
Grade_______ SCHOOL: ________________________________

Does student take medication: ___YES ___NO

Medication	Dosage	Hour(s) given

If your child requires medication at school, all medication sent to school must be in the original prescription container with a current date and the child's name. Also a "medication consent" form must be completed and signed by the physician and the parent and must be on file. Medication brought to the school by a student will not be given; a parent or guardian MUST bring the medication.

Health Insurance Information: *Please check appropriate blank.*
___Private Insurance ___CHIPS ____MCAN ____Other ____No Health Insurance
___Medicaid #________________________

Physician/Health Care Provider___________________________________ Phone No.______________________

Health Plan/Group Name____ Policy No.______________________

Dentist____ Phone No.__________________________

Vision and/or Hearing Information:
___Wears glasses/contacts: ___yes ___no ___Wears hearing aid(s) ___yes ___no

Medical Conditions: Please check the appropriate blank if your child has any of the following:
___Severe Allergies ___Food/Environmental ___Stinging Insect/Bees ___Medicines/Drugs
___Other
Please explain: ____
Requiring: _______Benadryl _______EpiPen Other___________________________________

___Asthma If checked, ____uses inhaler ____on daily medication
___Seizures If checked, on medication? ____Yes ____No
___Diabetes If checked, insulin dependent? ____Yes ____No
___ADHD ___ADD If checked, on medication? ____Yes ____No

___Other (please explain):____
___Recent illness, hospitalization or surgery. If checked, please provide date(s) description(s):
____
____

Please remember to keep all emergency contact information up to date, notify the school of any change of address, telephone number or other important changes that could affect the care of your child. *If you have any questions, feel free to contact Cleveland School District Health Services.* ***(04/13)***

EMERGENCY TREATMENT AUTHORIZATION

I the undersigned parent(s)______________________________
______________________, do hereby give authorization and consent to the school to obtain emergency medical care and necessary emergency transportation to a healthcare facility.

__________________________ ______________
Parent Signature Date

RELEASE OF MEDICAL INFORMATION

I hereby understand and authorize that my child's medical records or other medical information, furnished to the school, will be shared with school officials and emergency personnel who have a legitimate medical/educational purpose for accessing such medical records and information.

_____________________________ _______________
Parent Signature Date

EMERGENCY CONTACT INFORMATION

Parent Name____
____

Home Phone No.____________________________________
Cell Phone No._____________________________________
Work Phone No.____________________________________

Email:____

Alternate Contact

Name ____
Relation _________________________________
Phone No.:________________________________
Additional phone no. ________________________________