SIERRA-PLUMAS JOINT UNIFIED SCHOOL DISTRICT

Emergency Medical Information and Annual Health Inventory – *CONFIDENTIAL*

2023-2024

Child's Name: ________________________________ Birthdate: ___________

School: ____________________________________ Grade: _____________

Primary Doctor: ______________________________ Phone: ______________________________

Dentist: ____________________________________ Phone: ______________________________

Is your child under the care of a medical specialist (i.e., Ear doctor, allergist, orthodontist or psychologist)?
If so, please explain:____

Does your child take any medication ☐ Yes ☐ No List:____________________________________

Will medication need to be given during school hours? ☐ Yes ☐ No

Please note: Any medication (including over the counter) that needs to be given at school requires written instructions by a medical provider on an authorized form and special arrangements with the school nurse.

Please indicate if your child currently has, or has a history of, any of the following conditions:

☐ **No change in health from previous school year.**

☐ Allergies to bee stings, food, medications, or seasonal: ____

____ ☐ My child carries or uses an epinephrine auto injector.

☐ Asthma ☐ Serious illness or injury ☐ Hepatitis ☐ Wears hearing aides

☐ Hearing problems ☐ Convulsions or seizures ☐ Rheumatic Fever ☐ Diabetes

☐ Frequent Headaches ☐ ADHD / ADD ☐ Frequent nosebleeds ☐ Frequent Stomach aches

☐ Serious head injury ☐ Heart disease ☐ Anorexia or bulimia

☐ Surgery for serious illness/injury ☐ Kidney disease ☐ Wears glasses

PLEASE EXPLAIN ANY ITEMS YOU HAVE CHECKED: ____

____

Does your child have any other condition that might affect learning? ______________________________

____

Does your child have any condition that requires special consideration in the classroom or for physical education?

____

Has there been any traumatic event in your family within the past 12 months that would affect your child's school experience adversely? ____

Parent/Guardian (1): ___________________________________ Phone 1: ______________________________

Phone 2: ______________________________

Parent/Guardian (2): ___________________________________ Phone 1: ______________________________

Phone 2: ______________________________

Street Address: ___________________________________ City: _________________ Zip: ___________

(*Please sign on page 2***)**

I, the undersigned parent/guardian of the student listed above, a minor, do hereby authorize and consent to any x-ray examination, anesthetic, medical, or surgical diagnosis rendered under the general or special supervision of any member of the medical staff and emergency room staff licensed under the provisions of the Medicine Practice Act or a Dentist licensed under the provisions of the Dental Practice Act and on the staff of any acute general hospital holding a current license to operate a hospital from the State of California Department of Public Health. It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required, but is given to provide authority and power to render care which the aforementioned physician, in the exercise of his/her best judgment, may deem advisable. It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the patient, but that any of the above treatment will not be withheld if the undersigned cannot be reached.

____________________ ____

Date **Signature of Parent/Guardian**

This authorization is given pursuant to the provisions
of Section 25.8 of the *Civil Code of California*.

This consent shall remain effective through June 30 of the current school year.

IF THERE IS ANY CHANGE IN THE CHILD'S HEALTH WHICH AFFECTS HER/HIS ABILITY TO TAKE PHYSICAL EDUCATION, OR IF SHE/HE IS PLACED ON REGULAR MEDICATION, (Educ. Code No. 49423) IT IS THE PARENT'S RESPONSIBILITY TO NOTIFY THE SCHOOL. PLEASE REQUEST FORMS AS NEEDED IF EITHER SITUATION EXISTS.