STUDENT NAME _____ GRADE _____

Medicaid/AR Kids # _____
Family Physician: _____ Phone: _____
Family Dentist: _____ Phone: _____
Other Health Care Professional: _____ Phone: _____

1. Does the student take any MEDICINE at home or at school regularly? _____YES _____ NO
   If yes, state name of medicine and time given, and reason for medication.
   _____
2. Is the student allergic to any medications or foods? _____Yes _____No
   If yes, state name and reaction symptoms.
   _____
3. Does the student have any health problems, which may limit or affect his or her activities at school or participation in the P.E. Program? (E.g. running, exercise, etc.) ___ ___Yes _____No
   If yes, explain: _____

**Please check if the student has or has had the following and explain areas checked:**

| | | | |
|---|---|---|---|
| ____Chicken Pox | ____Kidney Problems | ____Glasses/Contacts | ____Rheumatic Fever |
| ____Diabetes | ____Seizures | ____Tuberculoses | ____Fainting Spells |
| ____Nose Bleeds | ____Heart Trouble | ____Allergies | ____Asthma |
| ____Hearing Aids | ____Bladder Problems | ____ADD | ____Cystic Fibrosis |
| ____Excessive Bleeding | ____Bowel Problems | ____Migraine Headaches | |

Explanation of any of the above checked items.

_____

_____

May your child be given an age-appropriate dose of generic Tylenol? Yes ____ No ____
**This shall remain in effect as long as my child attends Yellville-Summit Schools.** (*We will try to reach you each time we feel your child needs Tylenol. This does not mean a child with fever or in a moderate amount of pain should come to school.)*

During a visit to the health room the following products may be used. **Please initial by the products you give consent to be used for your child.**

Antibiotic ointment _____ Cough Drops _____ Caladryl _____ Hydrocortisone cream _____
Tums _____ Carmex or Vaseline for chapped lips _____

***MEDICAL RELEASE***

We, the undersigned parent/guardian of _____(student's name), do hereby grant and give to Yellville-Summit Public Schools, and /or its designated staff member and representative, authorization and authority to treat and/or obtain emergency medical care for our child. Whether emergency exists or not or whether medical care is needed or not is left up to the sole discretion of the school or its representative. Further, we do hereby authorize and grant to the school district and/or its designated representative authority to approve any necessary medical treatment that is determined to be needed for our child either by hospital emergency room staff or by family physician.
We do herby designate _____ as our first physician of choice but if such physician is not available then we authorize the school district to select such doctor and /or hospital, as they deem necessary and appropriate.

Parent/Guardian Signature: _____ Date: _____