8HEALTH ROOM FORM 2017-2018

CHILD'S NAME _____ GRADE _____ AGE _____ DOB_____

***Contacts will be obtained from the Office Emergency Form**

●List any serious illness, injuries, or operations/medical issues

_____□NA

● Does your child have any allergies to food/medications/beestings?
_____□NA

- Does your child require an Epi-Pen for an allergic reaction? Yes □ No □
- Does your child take any medications? Yes □ No □ At school? _____

Name of medication _____Dose_____Frequency_____

***Please attach a school medication form, completed by the doctor, for medication to be given during the school day.**

Located at www.staug-md.org under forms

* I hereby authorize St. Augustine School's health officials to share health information and health history with the other staff members on a need to know basis. This includes the health room staff, homeroom and special teachers, teaching assistants and, only if deemed necessary by the teacher, parent volunteers in the classroom. The purpose of this disclosure is for the teachers to be prepared in advance for any medical emergencies.

I also authorize release of medical information to _____(name of child's physician) for the treatment of my student while attending St. Augustine School.

I also authorize release of medical information to St. Augustine School Health Room from _____(name of child's physician) regarding the treatment of my student while attending St. Augustine School.

This medical information will be from the health record that is maintained in the health room by the health room staff

This authorization is valid for one school year. It is valid from August 2015 through June 2016. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I also understand that this information is released to help with the treatment of my student while attending St. Augustine School.

_____ _____

Parent of Guardian Signature Date