Bellbrook High School

Student Health Record

First Name _____ Last Name _____ MI _____ Grade _____

Instrument/Color Guard _____

Address _____

DOB _____ Home Phone _____ Cell Phone _____

Parent/Legal Guardian – Mother

First Name _____ Last Name _____ MI _____

Mother's Employer _____ Work Phone _____

Parent/Legal Guardian – Father

First Name _____ Last Name _____ MI _____

Father's Employer _____ Work Phone _____

Parent/Guardian Email Address _____

Health History

PLEASE PUT A RESPONSE IN EACH LINE BELOW, IE, N/A, ---, OR A RESPONSE

Operation within the last year _____

Emotional problems _____

Serious medical problems _____

Orthopedic problem *(Please have student bring knee braces, show inserts, etc. to every rehearsal)* _____

Diabetes/Hypoglycemia_____ Specific diet/meds _____

Rheumatic Fever _____Epilepsy _____ Tetanus (date of last injection) _____

Other health problems in the past _____

Current student medications (list dosage & frequency of each) _____

_____

Is student permitted to take any over-the-counter medications, such as:

Aspirin ____ Tylenol ____ Ibuprofen ___ Antacids ____ Decongestants/Antihistamines ____ Motion Sickness Pills _____
Non-prescription Benadryl (bee stings & itching) _____

Is student currently under medical treatment? **YES or NO** (If yes) Reason _____

_____

Family Physician _____Phone _____

Family Dentist _____ Phone _____

Insurance Company _____ ID# _____ Group # _____

Parent/Guardian Signature: _____ Date _____

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Bellbrook-Sugarcreek Schools

EMERGENCY MEDICAL AUTHORIZATION

The purpose of this form is to enable a parent/guardian to ***authorize emergency treatment*** for their child who may become ill or injured under school authority when the parent/guardian cannot be reached or when an emergency occurs while the child is enroute to or from school on the school bus. The information contained on the Emergency Medical Authorization form will be shared with appropriate personnel. Reference O.R.C. 3313.712.

PLEASE PRINT except where a signature is required. Use BLACK PEN only.

Student's Name _____ DOB _____ Grade _____

Address _____ Phone _____

Building: Middle School or High School (circle one)

PART 1 – TO GRANT CONSENT

In the even reasonable attempts to contact me at *Home #* _____ *or Cell #* _____

OR my spouse at *Home #*_____ *or Cell #*_____ have been unsuccessful, I hereby give my consent for:

1. The administration of any treatment deemed necessary by:
   Dr. _____ (*Preferred Physician*) or
   Dr. _____ (*Preferred Dentist*) or, in the event the designation preferred practitioner is not available, but another licensed or dentist; and,
2. the transfer of my child to _____ (*Preferred hospital*) or any hospital reasonably accessible.

This authorization does NOT cover major surgery unless the medical opinions of two(2) other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained *before* the surgery is performed.

Following are facts concerning this child's medical history including, allergies, medications being taken and any physical impairment to which a physician should be alerted in case of an emergency

_____

_____

I certify by my signature that the information given above is correct and I understand that it is my responsibility as parent/guardian of this student to contact the appropriate school office and complete an updated authorization to change, modify, delete or add any of the designations and/or medical history certified by me this date.

Signature of responsible parent/guardian

_____

Date

_____

I give the district's school nurse permission to contact the above name health care provider as need for clarification of any health problems.

Signature of responsible parent/guardian

_____

Date

_____

PART 2 – REFUSAL TO CONSENT (Do not complete PART 2 if you completed PART 1)

I *do NOT give my consent* for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take no action or to: _____

_____

Signature of responsible parent/guardian _____ Date _____

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