ANCHORAGE CHRISTIAN SCHOOLS K5-12

STUDENT HEALTH INFORMATION & EMERGENCY MEDICAL TREATMENT CONSENT FORM
SCHOOL YEAR_____

Student's Name _____ Nickname_____ Grade ___ Sex M F

Primary Healthcare Provider _____ Phone _____

The Student Health Office is here to ensure your student is healthy and ready to learn. It is therefore, critical that all parents/guardians provide accurate and up to date information regarding their student's health. Please complete this form and return to the Student Health Office no later than the end of the first week of school. A form is required for each student, K5-12. This form is to be updated yearly, at the start of each school year and as it changes *immediately*. Contact the Student Health Office and speak to the School Nurse if you have any questions at 907-269-3815.

Is your student on any prescription medication(s) that will need to be given at school? ___ NO ___YES *If YES, a medication administration form and/or an action plan must be completed and signed by the prescribing physician and parent/guardian each year and/or when any changes in the medication/plan take place.*

Has your student been diagnosed by a licensed healthcare provider (MD, NP, PA, DO) with any of the following health conditions:

HEALTH CONDITION	YES	NO	Explain if "YES"
Medication Allergy			Medicine_____ Reaction_____
Food Allergy			Food(s): _____ Reaction:_____ Require an Epi-Pen? ___Yes* ___No
Allergy to Bee Sting			Require an Epi-Pen? ___Yes* ___No
Allergies (other)			
Asthma			Rate severity ___Mild ___ Moderate ___Severe Exercised Induced __Yes __No If yes, pre-medication required __Yes __No Medication taken at home_____ Do you use a peak flow? __Yes __No Asthma Healthcare Provider_____
Diabetes			Type____ Pump____ Pod____ Injection____ Diabetes Healthcare Provider_____
Seizures			Type_____ Medication_____ Date of last seizure_____ Triggers_____

Please list any other health conditions that you would like the school to be aware of as well as any medications, treatments, or accommodations that may be needed for the safety and well-being of your student. Include any related documentation from the student's provider:

_____

_____

Please indicate if the Health Office may administer acetaminophen (Tylenol) and/or ibuprofen (Advil or Motrin) to your student as needed for minor aches, menstrual cramps, and headaches:

Acetaminophen (Tylenol) yes ___ no___ Ibuprofen (Advil or Motrin) yes ___ no ___

As the parent or guardian of the above student, I have read, understand and completed this health information form. I consent for Anchorage Christian Schools to treat minor illnesses and injuries as needed and to release medical information as necessary to care givers in critical situations when a parent/guardian cannot be reached. I understand 911 will be call if deemed necessary without parental consent, and that I cannot ask the school not to call 911.

Printed Name _____

Signature _____ Date _____

Revised 02-07-2019