Student Health Form

Student Name: _____

Date of Birth: _____ **Entering Grade:** _____

TO BE FILLED OUT BY PARENT/GUARDIAN

First Aid Treatment: I hereby authorize BYDS personnel to use their judgement to administer the following first aid treatment to my child (Please check applicable boxes):

☐ Hydrogen peroxide 3% for minor cuts and scrapes
☐ Antibacterial Ointment: Polymyxin, bacitracin, and neomycin
☐ Anti-itch cream: Hydrocortisone acetate 1%
☐ Anti-itch cream: Diphenhydramine hcl 1% & Zinc acetate 0.1%
☐ Petroleum Jelly
☐ Cough Drop (5 years or older)

Pickup and Dismissal Other than Parent
The persons listed below have standing permission to pick up my child from the clinic. I will inform the school in writing of any other pick-up arrangements.

Name/Relation_____Phone#_____

Name/Relation_____Phone#_____

Name/Relation_____Phone#_____

Authorization & Release
In the event that I (or those designated by me to act on my behalf) cannot be reached to make arrangements for urgent and emergent medical attention for my child, I authorize the Head of School & Assistant Head of School (Dan Ahlstrom & Cynthia Kirsch) and any person designated by her to act on behalf of the school to do so. They have my full consent to take my child to the hospital of choice or can transport my child to the nearest emergency or hospital facility. That physician in charge has my consent for any and all necessary treatment for my child when in his/her care. I hereby release the Beth Yeshurun Day School, Dan Ahlstrom, Cynthia Kirsch and each of their designees from any and all claims or causes of action arising out of the direction of my child to any physician or other emergency medical personnel in accordance with this Authorization and Release.

Hospital of Choice: _____

Insurance Information: _____

Parent/Guardian Name: _____

Parent/Guardian Signature: _____Date: _____

BETH YESHURUN Day School

TO BE FILLED OUT BY PARENT/GUARDIAN & SIGNED BY PHYSICIAN

1. Does your child have allergies? ☐ No ☐ Yes (Food, drugs, seasonal, insects, other)
Allergic to_____ Severity/ Reaction_____

Allergic to_____ Severity/ Reaction_____

Are medications, other treatments, or an epinephrine injection required for allergies?
☐ No ☐ Yes ➡ Physician must fill out or provide an *Allergy Care Plan*

2. Has your child been diagnosed with the following health conditions?

ADD/ADHD ☐ No ☐ Yes ➡ If treatment needed during school hours, physician must fill out *Permission Form for Prescribed Medicine* or provide a written prescription along with the medication in the original bottle.		
Asthma ☐ No ☐ Yes ➡ Physician must fill out an *Asthma Action Plan Form*		
Diabetes ☐ No ☐ Yes ➡ Physician must fill out a *Diabetes Management Care Plan Form*		
Seizure disorder ☐ No ☐ Yes ➡ Physician must fill out a *Seizure Emergency Care Plan Form*		
Physician must provide a health care plan if treatment is needed during school hours:		
Heart condition ☐ No ☐ Yes	Sickle Cell ☐ No ☐ Yes	Deafness ☐ No ☐ Yes

3. Medications
Medication & Dosage At School? At School?
_____ ☐ No ☐ Yes* _____ ☐ No ☐ Yes*
IF YES, PLEASE FILL OUT MEDICATION PERMISSION FORMS & PROVIDE THE MEDICATION IN THE ORIGINAL BOTTLE LABLED WITH FIRST AND LAST NAME OF STUDENT.

4. Does your child have any disabilities, limitations, or other concerns? ☐ No ☐ Yes
If yes, please explain: _____

Physician Health Statement

*********Please attach a copy of the student's immunization record & fill out any care plan needed for health conditions.
This is to certify that the student listed has been examined by me on _____ (date) and found to be in good health and able to attend The Beth Yeshurun Day School as well as participate in age appropriate activities.

Physician Information

Name: _____Tel. Number (_____) _____

Signature: _____Date:_____