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%

☐ Aquaphor ointment (petrolatum 41%, mineral oil, Ceresin etc)

Medication Administration

In compliance with the Texas School Health Guideline, schools should not provide any medication for students; the parents must provide the medication. According to Section 22.052, Education Code, any medication administered to a student in a Texas school must have a written request/authorization from the student's parent or legal guardian and must be in the original container and be properly labeled. All medications, prescription and non-prescription are required to be kept in the clinic, with exceptions to emergency medications, if necessary. A written request from a parent or guardian shall contain:

- The student's name
- The name of the medication to be given
- Date of permission and a number of days the medication is to be given
- Time of day the medication is to be given; and
- Signature of parent or legal guardian
- **Prescribed medications** must have the pharmacy label on it and be accompanied by a doctor's signature and directions for administration during school hours

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 (Jennifer LeVine) 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, Jennifer LeVine, and each of her 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: _____________

COMPLETED BY PARENT/GUARDIAN

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*
Please list all medical conditions your child has. (Ex: Heart condition, sickle cell, hearing loss, eczema, lactose intolerance, etc.) If a care plan is necessary during school hours, please include it with a physician's signature.

IF YOUR CHILD WILL BE TAKING MEDICINE AT SCHOOL PLEASE FILL OUT MEDICATION PERMISSION FORMS & PROVIDE THE MEDICATION IN THE ORIGINAL BOTTLE LABLED WITH FIRST AND LAST NAME OF STUDENT, DATE BROUGHT INTO THE SCHOOL OR THE Rx LABEL ATTACHED TO THE MEDICATION.

3. Does your child have any disabilities, limitations, or other concerns? ☐ No ☐ Yes

If yes, please explain: ____

Parent/Guardian Signature: ____________________________________ Date: ______________

STUDENTS NEW TO BETH YESHURUN DAY SCHOOL

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 (______) ____________________

Physician Signature: ____Date:_________________