# Little Rines Early Childhood
# Parental Health Consent Form

(Please Print)

| Name of Student (Last, First, Middle): | Sex (Circle One): Male or Female | Phone: |
|---|---|---|
| Address:<br>P.O. Box # | Child's place of birth | West Bend Mallard SCD<br>Little Rines Preschool<br>(515) 887-7821 |
| City, State & Zip | Date of Birth: ____/___/____<br>Month/Day/Year | Social Security # |

| | |
|---|---|
| **Glasses** | Does your child wear glasses/contacts? Yes No<br>Date of last eye appointment: _____ |

| | |
|---|---|
| **Hearing** | Does your child have a hearing disorder? (Circle One): Yes No |
| | Hearing Devices? (Circle One): Yes No |

| | |
|---|---|
| **Medical Concerns** | List other concerns the school should know: |

| | | | |
|---|---|---|---|
| **Medication Information** | Does your child take any daily/routine medications? (Please Circle): Yes No | | |
| | List name of medications: | Time: | Reason for Medication: |
| | | | |
| | | | |
| | | | |

| | |
|---|---|
| **Allergies** | Please list allergies to... |
| | Medication: |
| | Food: |
| | Other: |
| | Other: |
| | Epi-pen required at school, provided by parent. (Circle One): Yes No |
| | Please describe allergic reaction. What signs/symptoms should we look for: |

**Please Complete other Side...**

| | |
|---|---|
| **Insurance Information** | Please circle what you have for this child:<br>Private Insurance Title 19 HAWK-I No Insurance<br>Name of Insurance _____ Medicaid # _____ |

Name of Physician: _____

Physician Address: _____

Physician Phone number: _____

Name of Dentist: _____

Dentist Address: _____

Dentist Phone number: _____

**Over-the-Counter Authorization and Emergency Release**

Medications at School: The following list of medications are available at school for the Secretary to give to your child, with written permission.

**Please mark the medications you would like your child to receive:**

| | |
|---|---|
| ☐ Acetaminophen (Tylenol)<br>☐ Ibuprofen (Advil or Motrin)<br>☐ Benadryl<br>☐ Antacids<br>** **A total of 10 doses will be given per year unless there is an order from a physician.** ** | ☐ None |

I give permission for the teachers to administer the above medications as needed in her judgment.

Parent/Guardian Signature: _____ Date Signed: _____

**Parent Information**

| | | | |
|---|---|---|---|
| 1) Name: | Home Phone | Work Phone | Lives with ☐Yes ☐No |
| Address: | Cell Phone | E-Mail Address | |
| 2) Name: | Home Phone | Work Phone | Lives with ☐Yes ☐No |
| Address: | Cell Phone | E-Mail Address | |

**People to call if above are not available...**

| | | |
|---|---|---|
| 3) Name: | Home Phone | Work Phone |
| Address: | Cell Phone | Relationship |
| 4) Name: | Home Phone | Relationship |
| Address: | Cell Phone | Lives with |

**Immuniz-ation**

Name immunizations your child has had in past year.

What:

**Need verification attached from Doctor or Clinic**

Given by (Circle One): Dr. Office ER/Hospital Public Health

**Authorization**

Please list names and relationship to child of people who can access to your child's health records....

Name:_____ Relationship: _____

Name:_____ Relationship: _____

Name:_____ Relationship: _____

**Emergency Release**

I give permission to the appropriate personnel of Little Rines Preschool to secure and authorize emergency medical care and treatment for my child, that in their judgment is necessary in the best interest of my child while under their supervision. I also agree to assume and pay for the fees for the emergency medical treatment as authorized in this statement. I understand that this health information sheet is confidential but the information will be shared with other Little Rines Preschool personnel as needed.

Parent/Guardian Signature: _____ Date Signed: _____