

Little Rines Early Childhood Parental Health Consent Form

(Please Print)

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

Glasses	Does your child wear glasses/contacts? Yes No
	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:
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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:			
	Private Insurance	Title 19	HAWK-I	No Insurance
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:	
	<input type="checkbox"/> Acetaminophen (Tylenol) <input type="checkbox"/> Ibuprofen (Advil or Motrin) <input type="checkbox"/> Benadryl <input type="checkbox"/> Antacids ** A total of 10 doses will be given per year unless there is an order from a physician. **	<input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> No
	Address: _____	Cell Phone _____	E-Mail Address _____	
	2) Name: _____	Home Phone _____	Work Phone _____	Lives with <input type="checkbox"/> Yes <input type="checkbox"/> 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 _____

Immunization	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: _____