Saint Clair Area School District
Health Update Form

Please complete and return to the nurse as soon as possible. The information will assist school personnel in the care of your child.

Student Name:_____ Birthdate:_____ Grade:_____

Address:_____ Home Phone:_____

Father's Name:_____ Work Phone:_____ Cell:_____

Mother's Name:_____ Work Phone:_____ Cell:_____

Email Address:_____

EMERGENCY CONTACTS

1. Name:_____ Relationship to child:_____ Phone:_____
2. Name:_____ Relationship to child:_____ Phone:_____
3. Name:_____ Relationship to child:_____ Phone:_____

HEALTH INFORMATION

Please list all allergies and type of reaction that occurs (Rash, swelling, breathing difficulty):

_____

Please list all health conditions (Asthma, Diabetes, Seizure Disorder, Heart, Stomach etc.):

_____

Please list all medications that your child takes at home or in-school:

_____

Please list any surgeries:_____

Please list any special needs that affect physical activity or education (Vision, hearing or mobility:

_____

Does your child have health insurance: ____Yes ____ No

Name/ Telephone number of Family Doctor: _____

PERMISSION TO TREAT

I give permission for my child to receive the following over the counter medications at school (Check mark means yes):

_____Tylenol (or generic brand)_____Antacid(without fever)_____First aide protocols as approved by School Physician

I give permission for my child to participate in the school fluoride program (Grade K-6 only): _____Yes _____No

I give permission for pertinent information be shared with teachers and administration: _____Yes _____No

Please refer to your child's agenda for the SCASD Policy on medications. Students are not permitted to carry medications during school hours. **If your child must take a medication (over the counter or prescribed) during school hours, please contact the nurse so all necessary paperwork is completed.**

Parent/Guardian Signature:_____ Date:_____

****PLEASE REMEMBER TO UPDATE EMERGENCY INFORMATION AS NEEDED****

Revised 8/2020