SCHOOL HEALTH SERVICES
Riverside School District
School Year: 2023 - 2024

In order to provide the best educational experience for your child, school faculty must understand your child's health needs. Please carefully read and complete the following:

Students Name:_____ GRADE & Homeroom #_____

I hereby give permission for my child to receive the following medical attention as part of the school health program:

1. **Height, weight, blood pressure, vision, and hearing screening. (6th , 8th , 9th & 10th grades)**
2. **A scoliosis screening examination by the school nurse on students in grades 6 through 12 (Screening is done biannually)**

Scoliosis is a lateral curve of the spine, most commonly found during the adolescent growth period. (Information when screening will take place will be sent home later in the school year).

***MEDICATION: Students are not permitted to carry medication in school. Only those students that require emergency medication (Inhaler, Epinephrine, Or Insulin) may carry as per medication policy. If your child will need to take any prescription or non-prescription (over-the-counter) medication (i.e. Ritalin, inhaler, epinephrine, insulin, eye drops, creams, antibiotics, pain reliever, etc.) a physician's order and parental written approval must be submitted to the school nurse before any medication may be administered. Medications will be kept in the Nurse's Office. Please contact the Health Office for the required School Medication Permission Forms or go to school Web page.**

Please check any allergies your child has:
____Peanut Bee Sting_____ Other (please specify)_____

If you checked any of the above, please describe the type of reaction your child has and any medications he/she may take for the reaction._____
_____

HEALTH RECORD UPDATE

***PHYSICAL EXAM: Those that are entering middle school and high school for the first time OR planning to participate in a school sport need to obtain school /state approved forms to be completed by a physician and submitted to school. (Sports Physicals are only valid for 365 days from date of exam). Forms can be obtained on School Web Page or Office.**

Has your child received any immunizations in the past year?
____No ____Yes (Please attach a doctor's note stating type and date(s) received.

Check any of the following medical conditions that your child has:

___Heart Condition	**___Seizure Disorder**	**___Vision (wears lenses)**
___Asthma	**___Frequent Headaches**	**___Hearing (wears aid)**
___Diabetes	**___Migraine Headaches**	**___ADD ___ADHD**

___Emotional (please describe)_____
___Other (please describe)_____

During the past year has your child experienced any illnesses, injury, or received surgery:
_____
_____

Current Medications: (See above medication policy for medication that must be administered at school)
_____
_____

"I understand that relevant information regarding my child's health may be shared with appropriate school personnel and other health care providers as necessary."

_____
Parent /Guardian – Please print. Parent /Guardian Signature Date