

**NORRIS SCHOOL DISTRICT 160
STUDENT'S YEARLY UPDATE**

FOR SCHOOL YEAR _____ TO _____
(and any summer sessions to follow, as applicable)

This form is for use at all grade levels and will serve to update your child's health and emergency information for the new school year. Completion of this form is required for participation in school-sponsored extracurricular activities and field trips. A parent/guardian should complete both sides of this form and sign. **COMPLETE ONE FORM FOR EACH CHILD ATTENDING NORRIS. PLEASE USE BLUE OR BLACK INK.**

STUDENT'S NAME: _____ Date of Birth ____/____/____ Grade _____

SIBLINGS & GRADE: _____

PARENTS

Mother: _____ Address: _____ City _____ Zip _____

H Ph: _____ - _____ Cell: _____ - _____ Employer: _____ W PH: _____ - _____

Email: _____

Father: _____ Address: _____ City _____ Zip _____

H Ph: _____ - _____ Cell: _____ - _____ Employer: _____ W PH: _____ - _____

Email: _____

Which parent should school call first: _____ **Which phone #** to call first: _____

If parents are divorced, with whom does this child live? _____

EMERGENCY/CONTACTS

Physician: _____ Ph: _____ - _____ Preferred Hospital: _____

Dentist: _____ Ph: _____ - _____ Child care: _____ Ph: _____ - _____

A family/friend contact if parent cannot be reached: _____ Ph: _____ - _____

Can this person transport your child home from school or to medical care if you cannot be reached? Yes No

Any additional instructions: _____

INSURANCE INFORMATION: Insurance Carrier/ Address: _____

Policy # _____ Policy Holder's Employer: _____

Do you plan to purchase the insurance provided by the school for your son or daughter? **Circle:** Yes No

EMERGENCY MEDICAL CARE: In the event that your child would require immediate medical attention during school, at a school-affiliated event, or in travel to a school event, Norris School District will, as the situation requires, contact an emergency service provider or seek medical care for your student from a physician. This physician might be one of the school's choosing if your student's physician is not available for the situation. Norris Schools will contact you as parent/guardian as soon as this would be possible.

As parent/guardian of _____ (insert student's name), I agree that I have completed the above information and will contact the school should this information change. I agree that I have read the above paragraph concerning emergency medical care and give my consent for the school to seek emergency care for my student should an emergency arise.

_____/_____
Signature of Parent/Guardian for Consent for Participation in School Activities, Including Field Trips, and Consent for Emergency Care **Date**

LIST ALLERGIES OR WRITE "NONE". (Do not leave blank) _____

CURRENT MEDICATIONS (Prescription and Over-the-Counter): **If medication has to be given at school, contact your school health office and see the Norris web site for medication permission forms.**

Medication	Dosage	Route	Time	Reason
1.				
2.				
3.				
4.				

DATE OF YOUR STUDENT'S LAST DENTAL APPOINTMENT: _____ / _____ / _____

MEDICAL CONDITIONS (check√) -- My student has been diagnosed with or has a history of the following:

___ **asthma**: Will there be an **inhaler at school?** **YES / NO** Who is the Prescriber? _____

___ **diabetes** ___ **anaphylactic allergy** ___ **seizures** ___ **cancer** ___ **heart problem**

___ **headaches** ___ **concussion history: date(s) of occurrence** _____

___ **vision problem**: glasses/contacts ___ **hearing difficulty**: left / right ___ hearing aid(s) left / right

Describe or provide instructions for the condition(s) you checked or add any other condition not mentioned above: _____

REQUEST TO PROVIDE MEDICATION AT SCHOOL: Place a check mark in front of the medication that can be given to your child and the reasons that this medication can be given. By signing below you agree that your child has received this medication before without problem. Your child's medication may be provided by a nurse, health aide, or other school personnel determined competent to provide medication by Nebraska law.

CHECK HERE IF YOU WISH TO BE NOTIFIED BEFORE YOUR CHILD TAKES THIS MEDICATION: _____

CHECK HERE IF YOU WISH TO BE NOTIFIED DURING THE DAY IF YOUR CHILD RECEIVED A MEDICATION: _____

CHECK HERE IF YOU DO NOT NEED TO BE NOTIFIED WHEN YOUR CHILD RECEIVES MEDICATION: _____

Acetaminophen dosage per age/weight and frequency per product labeling can be given for:

___ headache ___ sore throat ___ mild aches /pain ___ orthodontia pain ___ menstrual cramps
___ fever control prior to dismissal (parent contacted and student will be sent home)

Ibuprofen dosage per age/weight and frequency per product labeling can be given for:

___ headache ___ sore throat ___ mild aches /pain ___ orthodontia pain ___ menstrual cramps
___ fever control prior to dismissal (parent contacted and student will be sent home)

Menthol cough drops/throat lozenges

Calcium carbonate antacid tablets (like Tums®)

CONSENT FOR DISCLOSURE: Sign below to give Norris Health Office Staff permission to disclose your student's medical information on a need-to-know basis to those staff members who teach or supervise your child at school or school events. This can include providing a copy of this form for a staff member who supervises your student at a school activity; this information might be used when securing medical care.

_____/_____
Signature of Parent/Guardian for Consent for Disclosure Date

Sign here to identify parent/guardian completing this form: _____/_____
Parent/Guardian Date