



SCHOOL NURSE INTAKE FORM

Please do not leave any space blank, fill in NONE if the answer to any of the following is 'No'.

STUDENT NAME: _____ **Birthdate:** _____ **Grade:** _____

Please list any medical conditions.

For example: Asthma, Diabetes, seizures, ADHD, seasonal allergies, frequent nose bleeds, anxiety or heart conditions.

Please list any medically diagnosed allergies requiring a F.A.R.E plan for life threatening allergies.

Does your child take any medications at home? If yes, please list below...

Does your child take any medication during school hours that will be administered by the School Nurse? If so, please list MEDICATION NAME, DOSE and TIME TO BE GIVEN. Please send a new Salem Lutheran School Prescription Authorization form signed by you and the prescribing physician each school year.

Will you give the School Nurse permission to discuss the medical conditions and allergies of your student as needed with school staff? Ex. Activity restrictions due to injuries/fractures, etc. as needed YES or NO

Will you give the School Nurse permission to apply topical ointment (Bendryl cream and/or Hydrocortisone cream) to insect bites/stings and/or rashes? YES or NO

I understand that I will update the School Nurse in writing of any changes of my child's health condition or allergies via email during the school year at kleeveer@salem4u.com. I will read health topics and medication policies in the Family Handbook in order to be compliant.

Name of parent completing this form: _____ Phone: _____

Parent Signature: _____ Date: _____