

Student Health Registration Form 2021-2022

Child's Name _____
Last First Grade Date of birth

In order to ensure the health-safety of students at OSL, we are asking for any ALLERGIES or other MEDICAL CONDITIONS which should be brought to the attention of the staff.

_____ My child has NO known ALLERGIES or MEDICAL CONDITIONS

MEDICAL CONDITIONS

Please check if you have ever been told by a physician or health care professional that your child has:

_____ Asthma _____ Seizure disorder _____ Bleeding disorder _____ ADHD _____ Hearing loss _____ Eczema
_____ Diabetes _____ Skin condition _____ Heart condition _____ Vision (wears glasses/contacts)

Please provide information as needed:

ALLERGIES* (please list specific allergy)

Food(s) _____

Plants _____

Animals _____ Medication _____ Bees/Insects _____

Seasonal _____ Other _____

Please describe the allergic reaction and the **treatment** for each checked allergy.

Please notify the staff of any changes concerning any allergy or medical condition of your child.

MEDICATION

Does your child take any medication on a regular basis? Yes* _____ No _____ If yes, name of

medication(s) _____

Purpose _____

medication(s) _____

Purpose _____

Will medication be needed at school? No _____ Yes* _____ (Complete Medication Authorization Form)

*Please call to schedule a time to speak with the teacher and/or principal if specific information will impact your child, especially during the school day.

Parent signature Date

Emergency Procedure and Medical Release Form 2021-2022

Child's Name _____ Grade _____
Last First

I, _____ certify that my child is in good health and can participate in all normal activities of the group and that I have noted any exceptions below.

I understand that reasonable measures will be taken to safeguard the health and safety of the boys/girls and that I will be notified as soon as possible in case of emergency. However, in the event of sickness or accident, I will not hold the group leaders of Our Savior Lutheran School responsible. In the case of sickness, or accident, after reasonable attempts to reach us or an emergency contact person fail, we, the undersigned parents of _____, minor, do hereby consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital services that may be rendered to said minor under the general special instructions of any licensed qualified physician, whether such treatment is rendered at the office of a physician or licensed hospital. It is understood that consent is given in advance of any specific diagnosis or treatment being required but is given to encourage chaperones of Our Savior Lutheran School and said physician to exercise his/her best judgment as to the requirements of such diagnosis or treatment. I authorize the calling of the physician and/or the providing of other medical services at my expense.

_____ Date Signature of Parent/Guardian

Emergency Contacts (please put a * for parent contact priority):

Name: _____ Circle One: Father Mother Other _____

Work Place: _____

Phone: (_____) _____ (Home/Work/Cell) (_____) _____ (Home/Work/Cell)

Name: _____ Circle One: Father Mother Other _____

Work Place: _____

Phone: (_____) _____ (Home/Work/Cell) (_____) _____ (Home/Work/Cell)

Individual(s) to notify in case of emergency if parents cannot be reached.

Please mark the box if the individual(s) is/are also authorized to pick up child on days in addition to an emergency.

<input type="checkbox"/>	_____	_____	_____	_____
<input type="checkbox"/>	Name	Relation	Phone (Cell/Home)	Phone (Cell/Home)
<input type="checkbox"/>	_____	_____	_____	_____
<input type="checkbox"/>	Name	Relation	Phone (Cell/Home)	Phone (Cell/Home)
	_____	_____	_____	_____
	Name	Relation	Phone (Cell/Home)	Phone (Cell/Home)

Physician Information:

_____ Name Address Phone Number