Paramount Academy

Health and Medical Information/Authorization SY 2018-19

All spaces MUST be completed. Please write "none" if not applicable.

Student Legal Name:	**Date of Birth:**	**Gender:**
Grade: **Teacher:**		
Parent/Legal Guardian Name:	**Phone:**	
Parent/Legal Guardian Name:	**Phone:**	
Emergency Contact Name:	**Phone:**	
Emergency Contact Name:	**Phone:**	
Preferred Hospital:	**Doctor Name:**	**Insurance Company:**

Health/Medical Information (Please fill in all the blanks)

Allergies:[ ]Food(Additional form required) [ ]Medication [ ]Latex [ ]Environmental [ ]Epi-Pen Required [ ]Allergy Action Plan

If any box above is selected please explan:_____

Asthma:[ ]Seasonal [ ]Environmental [ ]Exercise Induced [ ]Inhaler [ ]Nebulizer [ ]Action Plan

Diabetic:[ ]Insulin Injections [ ]Insulin Pump [ ]Diet Controlled [ ]Diabetic Action Plan [ ]DR. Orders

Yes[ ] No[ ] Headaches/Migraines
Yes[ ] No[ ] Seizures/Epilepsy
Yes[ ] No[ ] Developmental delays
Yes[ ] No[ ] High blood pressure
Yes[ ] No[ ] ADHD/ADD
Yes[ ] No[ ] Frequent ear infections
Yes[ ] No[ ] Frequent Colds

Yes[ ] No[ ] Has/had hearing problems
Yes[ ] No[ ] Has/had tubes in ears
Yes[ ] No[ ] Has/had speech difficulties
Yes[ ] No[ ] Has/had hearing aides
Yes[ ] No[ ] Has/had vision problems
Wears: [ ]Glasses [ ]Contacts [ ]Hearing Aides

IEP: Yes[ ] No[ ] _____
504: Yes[ ] No[ ] _____
Under DR. care for:_____
P.E. Restrictions_____

***Doctor note must be provided for all Restrictions/Special Accomodations**

***Parent/Legal Guardian Approved Medication** *I approve Paramount Academy to give parent provided medication checked below

[ ]Tylenol [ ]Ibuprofen/Advil [ ]Cough Drops [ ]Itch Cream [ ]Benadryl [ ]Tums/Pepto

Paramount Academy does not supply or provide medication for student's. Medication must be provided by the parent.

Medication taken at home: Yes [ ] No [ ] **Medication taken at school: Yes [ ] No [ ]**

(Medical Form must be completed and medication must be provided to the office by parent/guardian. This includes prescriptions and over-the-counter medications)

Medication Taken	Dosage	Times Taken	Reason for Medication

Dr. Name:	**Dr. Phone # ( )**	**Dr. Signature:**

Do you need to speak with the health office staff? Yes [ ] No [ ]

Free Health Screening

Hearing and Vision Screening for specific grades is provided at no charge. Please see the front office for more details.

All information provided may be shared with the appropriate school staff and medical personnel unless otherwise requested.

By signing below, I, as the parent or guardian of the above-named student, affirm that the information provided on this form is accurate. Further, I herby agree and authorize **PARAMOUNT ACADEMY**, it's employees, administrators, and other personnal, to administer, or cause to be administered, any first aid, emergency medical care or other treatment perceived as necessary under the circumstances, including treatment by a doctor, paramedic, care facility, or hosptial of **PARAMOUNT ACADEMY'S** choice; that my child's injury or condition may be compounded, multiplied, or enlarged by negligent rescue operations or emergency procedures; and that I agree to take full responsibility, and expressly waive and release any claims my child or I may have, for such medical care or treatment, specifically including, without limitation, any negligent rescue operation, treatment or selection of medical personnel or facilities. I hereby give authority to any hospital, doctor and/or emergency medical services to render immediate aid as might be required at the time for his/her health and safety. It is my understanding by me that the expenses of this service will be accepted by me. In addition all medications and accomidations need to be approved, as we are a Health Office Facility not a Nursing Facility or Doctor's Office.

Parent/Legal Guardian Name (Please Print):_____

Signature:_____ **Date:**_____

Email:_____