

CONFIDENTIAL

Covenant Keepers Charter School

Student ID

Student's Name	Date of Birth	Grade	Parent Contact #
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Health Diagnosis	
Check all that apply (include date diagnosed):	
ADHD/ADD	<input type="checkbox"/>
Asthma (Asthma Action Plan REQUIRED)	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>
Seizures--Date of most recent SEIZURE:	
Past Surgeries	
_____	Date: _____
_____	Date: _____

Other Diagnosis(es)

Allergies	
(list known allergies for each category)	

Check here if no known allergies	<input type="checkbox"/> No allergies
Seasonal Allergies:	
Food Allergies:	
<i>Dietary Form and Food Allergy Plan must be completed by child's doctor and returned to school nurse before nutrition modifications may be made.</i>	
Epi-Pen provided	<input type="checkbox"/> Yes <input type="checkbox"/> No

Drug Allergies	
Other Allergies:	

Behavioral/Mental/Emotional Concerns	
Diagnosis	
Physician	
Therapist	

Permission is granted to give the following medications in an emergency situation only: Epinephrine, Benadryl, Albuterol.

yes no

Medications	
All medication must be given at home unless it is given more than 3 times per day or at a specific time as indicated on the prescription bottle. No over the counter (OTC) medications will be given.	
Home Medications, dosage, and date began taking	
1.	Date
2.	Date
3.	Date
School Medications, dosage, and date began taking (must complete consent form at school)	
1.	Date
2.	Date
Potential side effects from medications:	

Required Health Procedures or Special Services
 IMPORTANT: Doctor must fill out Individual Health Plan form (available in office) and procedures must be in place before student's first day of school.

List procedures	
Insurance/Health Care Provider Info	
ARKids/Medicaid (circle one)	Yes No
If yes, please give ID number	
Private Insurance (circle one)	Yes No
If yes, insurance company name	
Check here if your child does not have Health Insurance	<input type="checkbox"/> No Health Insurance
Eye Doctor/Ophthalmologist _____	
Does student wear glasses?	Yes No
If yes, for reading only?	Yes No
Does child wear contacts?	Yes No

Dentist	
Doctor and/or Clinic	Phone Number
Preferred Hospital	

Parental Consent

I give consent for emergency medical treatment. I understand that I will be responsible for payment of any and all medical care services, including but not limited to emergency care that is not covered by the student's health insurance. I give consent for this information to be shared with my child's teacher and appropriate school staff. I certify all information given is correct.

Parent Signature:

Date: