SCHOOL HEALTH SERVICES
Riverside School District
School Year: _____

In order to provide the best educational experience for your child, school faculty must understand your child's health needs. Please carefully read and complete the following:

Students Name:_____ Gr./Homeroom_____

I hereby give permission for my child to receive the following medical attention as part of the school health program:

1. **Height, weight, blood pressure, vision, and hearing screening. (6^{th}, 8^{th}, 9^{th} & 10^{th} grades)**
2. **A scoliosis screening examination by the school nurse on students in grades 6 through 12 (Screening is done biannually)**

Scoliosis is a lateral curve of the spine, most commonly found during the adolescent growth period. (Information when screening will take place will be sent home later in the school year).

***MEDICATION: If your child will need to take any prescription or non-prescription (over-the-counter) medication (i.e. Ritalin, inhaler, drops, antibiotics, Tylenol, etc.) a physician's order and parental written approval must be submitted before any medication may be administered. Please contact the Health Office for the proper medication permission forms.**

Please check any allergies your child has:
____Peanut Bee Sting_____ Other (please specify)_____

If you checked any of the above, please describe the type of reaction your child has and any medications he/she may take for the reaction._____
_____

HEALTH RECORD UPDATE

***PHYSICAL EXAM: Those that are entering middle school and high school for the first time OR planning to participate in a school sport need to obtain school approved forms to be completed by a physician and submitted to school. (Sports Physicals are only valid for 365 days from date of exam)**

Has your child received any immunizations in the past year?
____No ____Yes (Please attach a doctor's note stating type and date(s) received.

Check any of the following medical conditions that your child has:

___Heart Condition	**___Seizure Disorder**	**___Vision (wears lenses)**
___Asthma	**___Frequent Headaches**	**___Hearing (wears aid)**
___Diabetes	**___Migraine Headaches**	**___ADD ___ADHD**

___Emotional (please describe)_____
___Other (please describe)_____

During the past year has your child experienced any illnesses, injury, or received surgery:
_____
_____
Cuurrent Medications: _____

"I understand that relevant information regarding my child's health may be shared with appropriate school personnel and other health care providers as necessary."

Name of Parent /Guardian (Please Print) Parent/Guardian Signature Date