SOLDIER HOLLOW CHARTER SCHOOL

Parents,
To improve the well-being of your student in his/her educational setting, please provide the following information concerning any medical conditions which require special attention. All parents/guardians need to sign this form as designated. Thank you for your cooperation.

Name of Student: First: _____ Last: _____

Gender: _____ Grade: _____

Physician(s) _____ Phone _____

Dentist(s) _____ Phone _____

MEDICAL HISTORY: PLEASE CHECK APPROPRIATE BOXES. IF YES, PLEASE COMMENT.

NO	YES	Health Issues	Additional Info.
		Allergies*: (food, insects, drugs, latex, seasonal) List allergies:	Antihistamine needed at school? □Yes □No Epi-pen needed at school? □Yes □No
		Asthma*: Please check one. □Mild □Moderate □Severe	Check any that are needed at school: □Nebulizer □Inhaler □Epi-pen
		Diabetes*: Please check one: Type I □ Type II □	Insulin needed at school? □Yes □No □Pump □Pen □Syringe Glucagon needed at school? □Yes □No
		Seizures (Epilepsy)* Type:	**Date of Last Occurrence:**
		Other Health Issues*: (i.e. CP, DS, autism, ADHD, etc.)	
		Medications* needed at school (please use separate sheet of paper if needed). Type: _____ Dosage: _____ When: _____ Type: _____ Dosage: _____ When: _____	
		Does your child require any special health care procedure or device at school? (feeding tube, catheter, wheelchair, hearing aid, etc.)	
		Does your child have eye or vision problems? (explain) □Glasses □Contacts	

3444 W. 3000 S. Heber City, UT 84032 Phone: 435-654-1347 Fax: 435-654-1349

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If your child has any of the health issues marked with an asterisk or require any medication (i.e., inhaler, epi-pen, insulin, glucagon, etc.) to be used or administered at school, a Health Care Plan (HCP) form will need to be completed each year. Your physician's signature is required. For students with other health concerns, please contact the school office staff for the appropriate form. Health Care Plan forms and information regarding medication policy are available at the school office. Any questions should be directed to the office staff at soldierhollowmail@myshcs.org or 435-654-1347.

Parent/Guardian Acknowledgement:

- I understand that in case of accident/injury/illness to my student, the school will call an ambulance if deemed necessary. The school is not responsible for related costs.
- In case of an accident or illness that requires immediate trained medical care, parent/guardian authorizes the school to retain the services of a licensed medical doctor.
- I understand that the school/district does not carry insurance on students. Supplemental insurance is available for purchase and these forms may be picked up at any school.
- I also understand that all students entering Wasatch County School District must be up-to-date on immunizations or have the proper exemption documentation, and grades K-3 must have a current vision screening.
- If it is determined that my child needs a Health Care Plan, I understand that…
    - As a parent/guardian of the above named student, I give my permission to the school office staff to contact my child's health care provider.
    - I give permission for my child's health care provider to share information with the school office staff for the completion of the Health Care Plan.
    - I understand that the information contained in this plan will be shared with school office staff on a need-to-know basis.
    - It is the responsibility of the parent/guardian to notify the school office staff if ever there is any change in the student's health care status or care.
    - Parent/guardian is responsible for maintaining necessary supplies, medications, and equipment.
- I have read all of the above information.
- I have been provided with a copy (either paper or digital) of the procedures for student illness and administration of medication during the school day.

_____ _____

Signature of Parent/Guardian Date

_____ _____

Signature of Parent/Guardian Date