Nemo Vista Schools NURSE'S FORM

Student Health History and Emergency Medical Treatment Consent Form School Year _____

Student _____ Grade/Teacher _____

Student's doctor/healthcare provider: _____ Phone# _____
Insurance Information: _____ Private Insurance _____AR Kids A or B _____No Insurance

This is notification the district may provide your student's vision and hearing screening and personally identifiable information to a third party billing agent for the purpose of billing Medicaid if you have provided written consent. You may withdraw consent at any time.
Medicaid # _____ Parent/Guardian signature _____

If your child does not have health insurance, would you be interested in learning more about ARKids First, a free state health insurance program for eligible children under 18 years old? ☐YES ☐ NO

INDICATE IF STUDENT HAS BEEN DIAGNOSED BY A LICENSED HEALTHCARE PROVIDER WITH ANY OF THE FOLLOWING:

Health Condition	**Yes**	**No**	**Explanation if "Yes"**
Medication Allergies	☐	☐	List:
Food Allergies	☐	☐	Food(s): ☐peanut ☐ dairy ☐ eggs ☐other _____ Rate the reaction: ☐mild ☐ moderate ☐ life-threatening Does your child require an EpiPen? ☐Yes ☐ No
Allergy to Bees Stings	☐	☐	Rate the reaction: ☐ mild ☐ moderate ☐life-threatening Does your child require an EpiPen? ☐Yes ☐No
Allergies (other)	☐	☐	List:
Diabetes	☐	☐	☐Type 1 (Insulin Dependent) ☐ Type 2 Diabetes medications(s) taken at home:
Seizure Disorder	☐	☐	Type of Seizure: Medications:
Neurological Disorder	☐	☐	Specify:
Heart Condition	☐	☐	Specify:
Blood Disorder	☐	☐	Specify: Treatment:
Cancer	☐	☐	Specify Treatment:
Bowel/Bladder Issue	☐	☐	Specify:
Migraine Headaches	☐	☐	Triggers: Treatment:
Hypoglycemia	☐	☐	Treatment:
ADD/ADHD	☐	☐	Medication for ADD/ADHD:
Mental Health Behavioral Issues	☐	☐	Specify: Treatment/ Medication:
Wears Glasses/Contacts	☐	☐	☐Glasses ☐ Contacts → ☐For Distance ☐For Reading
Hearing Loss	☐	☐	☐Hearing Loss Right Ear ☐ Hearing Loss Left Ear ☐ Hearing Aid(s)
Serious Injury	☐	☐	Specify: Date(s)
Surgery	☐	☐	Specify: Date(s)
Medication Taken at Home (if not already listed)	☐	☐	List:

Please Check:
☐No health concerns at this time ☐ I understand that the medical information provided above is confidential, but may be shared when indicated, with those that need to know in order to provide a safe environment for my child.

FINANCIAL RESPONSIBILITY: The school does not resume responsibility, but does wish to provide the best service possible in an emergency. If the parent/guardian cannot be reached at the time of the emergency and if immediate observation or treatment is urgent in the judgment of the school authorities, I authorize and direct the school authorities to activate the community 911 system with ER transportation to the local hospital or ER facility assessable.

Parent/Guardian signature: _____ Date: _____