

**OSMOND COMMUNITY SCHOOL 2011-2012**  
**DEPARTMENT OF HEALTH SERVICES**

Child's Name: \_\_\_\_\_ Grade: \_\_\_\_\_

Dear Parent:

Please answer the following questions and return to your child's teacher or the Principal's office. This information will be recorded on their permanent record card.

1. Has your child had any serious illness or injury the last year that would limit his/her activity?  
YES \_\_\_\_\_ NO \_\_\_\_\_ If yes, please explain:

\_\_\_\_\_

2. Is he/she afflicted with any of the following? Please circle.

Diabetes      Asthma      Allergies      Hayfever      Epilepsy      Orthopedic Health

Please list allergies, type of reactions, and treatment measures:

\_\_\_\_\_

3. Does he/she take any regular medications? YES \_\_\_\_\_ NO \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

4. If any other new health problems exist, please explain: \_\_\_\_\_

\_\_\_\_\_

5. Did your child have any corrections during this summer?

Eyes: Fitted with glasses \_\_\_\_\_ Optometrist: \_\_\_\_\_

Ears: Reason \_\_\_\_\_ Doctor: \_\_\_\_\_

Teeth: Work done \_\_\_\_\_ Dentist: \_\_\_\_\_

6. List any vaccinations or immunizations received this summer: \_\_\_\_\_

\_\_\_\_\_

7. If an emergency arises with your child and we are unable to notify you, name who we should contact:

NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

RELATIONSHIP TO CHILD: \_\_\_\_\_

8. If a critical emergency arises and we are unable to contact you or the above name person, do we have your permission to call your family doctor and follow his recommendations?

YES \_\_\_\_\_ NO \_\_\_\_\_

DOCTOR: \_\_\_\_\_ PHONE: \_\_\_\_\_

DATE

PARENT'S SIGNATURE

HOME PHONE

WORK PHONE

E-MAIL ADDRESS

**\*\* IT IS VERY IMPORTANT THAT WE ARE ABLE TO REACH YOU DURING SCHOOL HOURS.**

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**OSMOND COMMUNITY SCHOOL 2011-2012  
Medical Information**

Child's Name: \_\_\_\_\_ Grade: \_\_\_\_\_

\_\_\_\_\_  
Hospital/Clinic Preference

\_\_\_\_\_  
Physician's Name

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Insurance Company

\_\_\_\_\_  
Policy Number

\_\_\_\_\_  
Allergies/Special Health Considerations

I authorize all medical and surgical treatment, X-ray, laboratory, anesthesia, and other medical and/or hospital procedures as may be performed or prescribed by the attending physician and/or paramedics for my child and waive my right to informed consent of treatment. This waiver applies only in the event that neither parent/guardian can be reached in the case of an emergency.

\_\_\_\_\_  
Parent's/Guardian's Signature

\_\_\_\_\_  
Date

I give permission for my child to go on field trips. I release Osmond Community School and their employees from liability in case of accident during activities related to Osmond Community School, as long as normal safety procedures have been taken.

\_\_\_\_\_  
Parent's/Guardian's Signature

\_\_\_\_\_  
Date

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