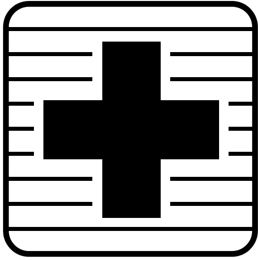

School District of Tomorrow River

HEALTH SERVICES

Heather Schultz, School Nurse

357 N. Main Street, Amherst, WI 54406 Phone (715)824-5523 ext. 425 Fax (715)824-5474

Student's Name:	**DOB:**
School Attending:	**Grade:**
Date:	**Bus Student:** Yes No
Health Condition:	

1. **Date of the last medication evaluation:** ________________

2. **Describe your child's condition:** ____

____

3. **Does it require alterations in the school setting?**
   - ☐ **Yes**
   - ☐ **No**

   If yes, please clarify ____

____

4. **Are there any restrictions or precautions?**
   - ☐ **Yes**
   - ☐ **No**

   If yes, please clarify ____

____

5. **Does your child take medication at home for this condition?**
   - ☐ **Yes** **Medication:** ________________________ **Dose:** _________________ **Time taken:** ______________
   - ☐ **No**

***<u>If your child requires medication at school you must follow the ADMINISTRATION OF MEDICATION TO STUDENTS POLICY. THE FORM REQUEST FOR GIVING MEDICATION AT SCHOOL FORM MUST BE FILLED OUT AND SIGNED BY PARENT AND PHYSICIAN.</u>**

EMERGENCY CONTACTS

MOTHER	**FATHER**	**OTHER**
Name: _______________________	**Name:** ___________________________	**Name:** __________________________
Home#: ______________________	**Home #:** __________________________	**Home #:** _________________________
Work #: ______________________	**Work #:** __________________________	**Work #:** _________________________
Cell #: ________________________	**Cell #:** __________________________	**Cell #:** __________________________

Doctors Name: ____ **Phone:** ____

I hereby authorize the release this information to appropriate school and bus personnel and classroom teachers.

Parent/Guardian Signature: ____ **Date:** ___________________

School Nurse Signature: ____ **Date:** ___________________

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