Dayspring Christian Academy Health Profile and Consent

2024-2025 School Year

Student Name:_____ **Grade:**_____

Emergency Contact: MUST HAVE TWO

Name	Relationship	Phone Number
Name	Relationship	Phone Number

Allergies:

Life threatening/Anaphylactic allergies (food, insect bites, drug allergy): Yes____ No____
If YES, please list the allergies:_____

Does your child require an EpiPen? Yes**____ No____

**Please complete the Administration of Emergency Use Prescription Medication form.

Asthma:

Does your student have any diagnosis of asthma? Yes____ No____
If yes, does your student use an inhaler? Yes____ No____

Will your student have an inhaler at school? Yes**____ No____
**Please complete the Administration of Emergency Use Prescription Medication form.

Seizure Disorder:

Does your student have a seizure disorder? Yes____ No____
Types of seizure_____ Date of last seizure_____

If yes, does your student require emergency medication? Yes**____ No____
**Please complete the Administration of Emergency Use Prescription Medication form.

Other Health Concerns/Medications:

Check all that apply:

- ADD/ADHD
- Heart Disease/High blood pressure
- Diabetes
- Kidney Disorders
- Neurologic Disorders
- Sickle Cell
- Headaches
- Bleeding Disorders
- Weight or Eating Disorders
- Hearing Problems
- Cancer
- Anxiety/Depression
- Anemia
- Cystic Fibrosis
- Stomach Disorders
- Immunodeficiency
- Orthopedic Disorder
- Vision/Color Deficit
- Other:_____

Hospitalization/Surgeries:_____

Any recent changes at home that we should be aware of?

_____

_____

By signing below, you give permission to the school nurse at Dayspring to administer first aid to your student. This includes the following medications:

- Bacitracin Antibiotic Ointment
- Hydrocortisone 1% itch relief cream
- Aloe Vera Gel
- Normal Saline eye rinse
- Burn Gel
- Cough Drops

NOTE: If you wish for your student to receive Tylenol (325mg Tablets), Advil (200mg Tablets), or TUMS, you must have the Medication Consent form filled out by a medical provider. If they order medication that we do not have, you must provide it.

Signature of parent consenting to treatment:_____