

**CONFIDENTIAL**

Every Student at DCA Must Complete This Annually

**DCA HEALTH INFORMATION**

TO BE FILLED OUT BY PARENT/GUARDIAN

Student Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Grade: \_\_\_\_\_

DCA will provide the following medications to students on an as needed basis at school. It is understood that the medication is administered solely at the request of and as an accommodation to the undersigned parent or guardian. Therefore the undersigned parent or guardian agrees to release DCA and its personnel from any legal claims arising out of the administration or failure to administer the medication to the student.

**PLEASE CHECK THE MEDICATION(S) TO WHICH YOU GIVE PERMISSION FOR THE SCHOOL TO ADMINISTER TO YOUR CHILD.**

Acetaminophen (Tylenol) \_\_\_\_\_  
Neosporin Ointment \_\_\_\_\_

Ibuprofen \_\_\_\_\_  
Cough Drops \_\_\_\_\_

**\*\*A Medication Permission Form must be completed for any other over the counter medication you wish to have dispensed at school.**

**Check the box, if any of the items listed below apply to your child:**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Vision Problem (glasses or contacts)   | <input type="checkbox"/> Migraines/Severe Headaches                              | treatment: _____                            |
| <input type="checkbox"/> Hearing/Earaches   | <input type="checkbox"/> Blood Disease   | <input type="checkbox"/> Seizures/Epilepsy* |
| <input type="checkbox"/> Past Head Injury   | <input type="checkbox"/> Bone/Joint Disease                                      | <input type="checkbox"/> Speech Difficulty  |
| <input type="checkbox"/> Heart Condition  | <input type="checkbox"/> Depression  | <input type="checkbox"/> Stomach/Ulcer      |
| <input type="checkbox"/> Eating/Sleeping Problem  | <input type="checkbox"/> ADD/ADHD or Learning Disorder                           | <input type="checkbox"/> Asthma*            |
| <input type="checkbox"/> Diabetes   | <input type="checkbox"/> Dislocated/fractured/repeated injury to a bone or joint | <input type="checkbox"/> Allergies*         |
| <input type="checkbox"/> Has your student ever passed out or been unconscious? If yes please explain. |  | <input type="checkbox"/> Food Allergies*    |
|   |  | <input type="checkbox"/> Other              |

**List food or drug allergies**

**If you checked any of the above, please briefly comment.**

**Is your student under medical care?**  Yes  No

Describe medical issue \_\_\_\_\_

*Please put additional information on a separate sheet if necessary.*

**Does your student take daily medication?**  Yes  No

Name of medication(s) \_\_\_\_\_

Dosage \_\_\_\_\_

**Will any medication or medical device (i.e. inhaler) be needed at school?**  Yes  No

**\*If yes, a medical permission form and/or care plan will need to be completed and signed by your physician.**

**EMERGENCY CARE PERMIT:** When a child suffers any injury or illness while in school, an immediate and continuing effort will be made to contact the parents. In case of serious injury or illness, first aid will be rendered in accordance with DCA policies. I understand that students with medical emergencies will be transported to the nearest emergency facility. If ambulance service is necessary, parents must assume financial responsibility and any associated costs.

- In the event of an emergency, I give permission for my son/daughter to be transported to the nearest emergency facility.
- I give permission for health information to be shared with adults in the school setting who will be working with my child on a need to know basis.
- I recognize that it is my responsibility to notify the school or Health Services Coordinator whenever there is a change in the student health status or care.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

Student: \_\_\_\_\_

Grade: \_\_\_\_\_

Father: \_\_\_\_\_

Place of Employment: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Mother: \_\_\_\_\_

Place of Employment: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

**Emergency Contact Information:** (people other than parents)

\_\_\_\_\_  
(Name)

\_\_\_\_\_  
(Relationship)

\_\_\_\_\_  
(Address, City, State)

\_\_\_\_\_  
(Phone)

\_\_\_\_\_  
(Email)

\_\_\_\_\_  
(Name)

\_\_\_\_\_  
(Relationship)

\_\_\_\_\_  
(Address, City, State)

\_\_\_\_\_  
(Phone)

\_\_\_\_\_  
(Email)

Physician: \_\_\_\_\_

Phone: \_\_\_\_\_

Dentist: \_\_\_\_\_

Phone: \_\_\_\_\_

Hospital: \_\_\_\_\_

Phone: \_\_\_\_\_

Insurance: \_\_\_\_\_

Insurance Number: \_\_\_\_\_

**Please return this form to Dayspring Christian Academy-Attn: Kelley Launer/Registrar  
3734 W. 20<sup>th</sup> Street, Greeley, CO 80634-3429  
(970) 584-2580-Registrar Direct (970) 330-1151-School's Main Line or fax to: (970) 330-0565  
Or email to: [klauner@dayspringeagles.org](mailto:klauner@dayspringeagles.org)**