CAP CANA HERITAGE SCHOOL
SCHOOL NURSE INFORMATION
(2017-2018)

This form must be completed by the parents or guardians.

Student Name: _____ **Grade:** _____

Parent/Guardian Name: _____ **Cell:** _____ **Phone:** _____

Blood Type: _____ **Date:** _____

Mi child has health insurance: Yes ( ) No ( ) **Company:** _____ **Policy No:** _____

Name of Doctor: _____ **Phone:** _____

Please mark any of the following conditions that pertain to your child:

Problems with:

- ☐ **Vision**
- ☐ **Auditory**
- ☐ **Emotional disorder**
- ☐ **Issues with menstural cycle**
- ☐ **Asthma ____ Severe ____ Light**

Chronic Illnesses:

- ☐ **Diabetes**
- ☐ **Kidney function**
- ☐ **Epilepsy**
- ☐ **Cancer**
- ☐ **Heart problems**
- ☐ **Other** _____

The school has parental consent to administer the following medicine(s) to your child:

☐ **Anti-Inflamatories**	Yes ( ) No ( )	☐ **Antihistamines**	Yes ( ) No ( )
☐ **Inhaler for asthma**	Yes ( ) No ( )	☐ **Antiacids**	Yes ( ) No ( )
☐ **Aspirin**	Yes ( ) No ( )	☐ **Petobismol**	Yes ( ) No ( )
☐ **Acetaminophen**	Yes ( ) No ( )		

Specify if your child has any type of allergy:

- ☐ **Medicinal**
  _____
- ☐ **Environmental**
  _____
- ☐ **Food Related**
  _____

My child takes medicine daily in: ☐ **House** ☐ **School**

- ☐ **Name of medicine:**
  _____
- ☐ **Reason for taking medication :**
  _____

Comments: _____

_____

_____

In case of emergency, notify:

1- Complete Name: _____

Phone #: _____ Relation to Student: _____

2- Complete Name: _____

Phone #: _____ Relation to Student: _____

People authorized to pick up student in case of emergency:

Complete Name: _____

Phone #: _____ ID #/Passport: _____

Complete Name: _____

Phone #: _____ ID #/Passport: _____

Complete Name: _____

Phone #: _____ ID #/Passport: _____

I, _____ authorize CCHS to give medical attention to my child at the closest clinic in case of an emergency.

I certify that the information offered in this document is correct and up to date. I agree to give updates to the school on a regular basis on the conditions that my child might have or requested by Cap Cana Heritage School I understand that I am required to inform the school immediately if my child has a disease or there is a change in an existing condition. I acknowledge that Cap Cana Heritage School will do its best effort in caring for the well-being of my child.

- Students that require medication at school must bring a written prescription from the doctor and must submit written parent consent to be administered at school. Contact the Nurse's Office at 809-695-5519 to obtain the form.
- The Nurse's Office may share some pertinent and important information with teachers and other school officials in particular cases for the well-being of the child.

Note: This Health form should be signed by both parents and/or guardians, if more than one.

Father/Guardian	Mother/Guardian
Name (Print): _____	Name (Print): _____
Signature: _____	Signature: _____
Date: _____	Date: _____