CUSTER SCHOOL DISTRICT 16-1
HEALTH FORM/CONSENT FOR TREATMENT

Student Name_____ Date of Birth: _____

Primary Contact _____ Phone # _____

Secondary Contact _____ Phone# _____

Emergency Contact _____ Phone#_____

Allergies and reaction: _____

_____

☐ Insulin ☐ EpiPen ☐ Inhaler ☐ Benadryl (**Parental consent and pre-approval by PCP required; See Appendix P)**

Other Existing Medical Conditions: _____

_____

Current Medications _____

Other health care information we should know about this student: _____

_____

_____

Family Physician: _____ Medicaid: Yes No Private Insurance: Yes No

I hereby authorize the above emergency contact to make any medical decisions concerning my child in my absence in the case medical treatment is needed for the school year _____ to _____.

I hereby further authorize consent to any medical services that may be required to treat the above-named child in my absence should medical treatment be needed, and the above-named agent(s) are unavailable.

I understand this information may be shared with school staff to meet this student's health needs. If you would like to visit further with the school nurse, please call the school.

Your signature below will authorize access to South Dakota Immunization Information System (SDIIS) for this student's immunization history.

Parent/Guardian Signature: _____ Date: _____