



PULASKI COUNTY SPECIAL SCHOOL DISTRICT

925 East Dixon Road/P.O. Box 8601
Little Rock, Arkansas 72216
www.pcssd.org

STUDENT HEALTH FORM

Form with fields for Date, Medicaid #, School Year, Student, Birthdate, Grade, Address, Home Phone Number, Daytime/Best Contact Number, Parent/Guardian Names, Email, Preferred Physician, Dentist, Emergency Contact other than parent, Contact #, Relationship to student.

MEDICAL HISTORY & HEALTH CONCERNS

Table with 5 columns listing various medical conditions such as Anxiety, Cardiac Disorder, Endometriosis, Meningitis, Seizures, ADD/ADHD, Celiac Disease, Ear Infections, Multiple Sclerosis, Sickle Cell Anemia, etc.

Automobile accident with significant injury: Fracture/Broken Bones:
Bowel/Bladder problems: Surgery:
Fracture/Broken Bones: Other concerns not listed above:

FOOD ALLERGIES: OTHER ALLERGIES:
Physician orders are required for any nutrition restrictions.

Has your child had any allergic reactions requiring medical attention? Yes No Epi-Pen Yes No

Current Medications:
All medication must be given at home unless it is to be given more than 3 times a day or at a physician ordered specific time.

SCREENINGS

Health screenings for vision, hearing, scoliosis, height, and weight are required by law according to the state of Arkansas for specific students according to grade level.

I give permission for my student to participate in the following health screenings:

Height/Weight (Act 1220 of 2003) YES NO Scoliosis (Act 95 of 1987) YES NO
Screening done for 6th & 8th grade girls; 8th grade boys

Parent Signature:

MEDICAL AUTHORIZATION

If my child, becomes ill or injured at school, I,
authorize school personnel to call and or arrange for transportation of my child to receive medical care. I understand that I will be responsible for payment of any and all medical care services, including but not limited to emergency care that is not covered by the student's health insurance plan.

Parent Signature: Date: