

Dodgeville School District
Student Health Information and
Authorization for Emergency Medical Treatment

Dodgeville School District appreciates your help in updating your child's health and emergency information each school year so that staff can take the best possible care of him/her at school. Please fill out this information sheet, sign and return it to school immediately. For special problems or concerns please contact the school nurse after completing the form.

Student's Name Birth Date Sex School Grade
Parent/Legal Custodian Name and Address Home Phone Daytime Phone Cell Phone
Family Doctor/Clinic/Town/Phone Number Family Dentist/Town/Phone Number

STUDENT MEDICAL HISTORY:

Table with 4 columns: No Health Concerns, No Known Allergies, Scoliosis, and other medical conditions like Asthma, Diabetes, Convulsions, ADD/ADHD, Anxiety, etc.

Please explain special health problems:

ALLERGIES:

Please describe the item allergic to, the allergic reaction and treatment; [] Epipen [] Antihistamine or Benadryl

Does your child's health problem(s) affect his/her daily living or school participation: YES NO If YES, please explain:

List and give any significant, injuries, deformities or operations:

Is the student required to take medication or treatments regularly either [] at home [] at school? YES NO

If YES, please list medications & reason for taking:

List any special needs for riding school bus: _____

Student Health Care Authorizations 2021-2022

Wisconsin Immunization Registry (check one)

_____ I authorize Dodgeville School District to release immunization information concerning my student to the Wisconsin Immunization Registry (WIR) and my child’s medical provider. WIR allows this information to be accessed securely by health care providers and assists in maintaining a complete and accurate immunization record for the child.
_____ I do NOT authorize Dodgeville School District to release immunization information concerning my student to the Wisconsin Immunization Registry (WIR).

Accident Medical Insurance (check one)

I understand that the Dodgeville School District does NOT provide accident medical insurance for students for school-related injuries, but does offer student accident insurance for voluntary purchase. I have received the information and application for this program.
_____ I will enroll my child in the program.
_____ I will NOT enroll my child in the program.

Student Screening (check one)

_____ I authorize the Dodgeville School District to routinely screen my child’s vision, hearing, height and weight at school. If I do not want my child screened, I will contact the school district nurse in writing with that information.
_____ I do NOT authorize the Dodgeville School District to routinely screen my child’s vision, hearing, height and weight at school.

Emergency Medical or Dental Treatment (check one)

_____ I authorize the principal or his/her designee to transport and seek emergency medical or dental treatment when the need for such treatment is immediate and when efforts to contact me are unsuccessful. This authorization shall remain effective for the full school year unless revoked in writing and delivered to the Dodgeville School District. I understand that the Dodgeville School District, its employees and its Board of Directors assume no liability of any nature in relationship to the transportation or treatment of the said minor. I further understand that all costs of EMS transportation, hospitalization, examination, x-ray, or treatment provided in relation to this authorization shall be my responsibility.

_____ I do NOT authorize or consent to emergency medical or dental treatment for my child. Please relate the procedure to follow if the child has problems, until the parent can be contacted: _____

I understand that the medical information provided above will be shared, if indicated, with those who need to know in order to provide a safe environment for my child.

Signature of Parent/Legal Guardian

Date

Contact Number