SUCCESS ACADEMY GRADES K-5 — Student Health Services — CAREER ACADEMY

Student Health and Medication Form

Studnets' Name: _____

Grade: K 1 2 3 4 5 6 7 8 9 10 11 12

Date of birth: _____

Parent/Guardian: _____

Home Number: _____

Cellphone Number: _____

Medical History

- ☐ Asthma
- ☐ Seizures
- ☐ Diabetes
- ☐ Digestive issues
- ☐ Food allergies ⟶ which foods: _____
- ☐ Bowel/Bladder issues
- ☐ Hearing Loss
- ☐ Vision problems
- ☐ Other, please explain: _____

Consent for Over-the-Counter Medications

(Only valid if Parent/Guardian checks off and signs below)

Tylenol or Ibuprofen	☐ Yes	☐ No
Notify me when my child takes any.	☐ Yes	☐ No
Antacids/Tums	☐ Yes	☐ No
Notify me when my child takes any.	☐ Yes	☐ No
Cough Drops	☐ Yes	☐ No
Notify me when my child takes any.	☐ Yes	☐ No

Parent/Guardian Signature: _____ Date: _____

Please make sure your students' immunizations are up to date.
All prescription medications must have a doctors order.
A new Emergency Form is required every year, thank you!

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Required Immunizations

Indiana State Law requires that all students be properly immunized for the health and safety of all students. You must provide the school with a complete and up to date copy of all of the required immunizations. The copy must be documented by your health care provider, health department where the child received the immunizations, or must be from an official copy of the official immunization record from the child's previous school. A complete and up to date copy of all of the above listed immunizations for your students' grade level must be provided within the first 20 days of school.

The record must include ALL of the following immunizations:

K – 3rd Grade	5 DTap	3 Hepatitis B	2 Polio	2 Varicella	2 MMR	*2 Hepatitis A	
6th Grade	5 DTap	3 Hepatitis B	4 Polio	2 Varicella	2 MMR	*1 Tdap	*1 MCV
12th Grade	5 DTap	3 Hepatitis B	4 Polio	2 Varicella	2 MMR	1 Tdap	*2 MCV

*The highlighted vaccines indicate those that students are due for at that grade level.

Consent to enter Immunizations into C.H.I.R.P.

I, _____, give Career/Success Academy , permission to put the following information concerning my student, _____, into the Indiana State Department of Health's Children and Hoosiers Immunization Registry Program (CHIRP):

- ✓ NAME
- ✓ DATE OF BIRTH
- ✓ IMMUNIZATIONS RECEIVED AND THE DATES THEY WERE ACQUIRED
- ✓ PARENT/GUARDIANS FIRST NAME

I understand that the information in the registry may be used to verify that my student has received proper immunizations and to inform me or my student of his/her immunization status or that an immunization is due according to recommended immunization schedules.

I understand that my student's information may be available to the immunization data registry of another state, a healthcare provider or a provider's designee, a local health department, an elementary or secondary school, a child care center, the office of Medicaid policy and planning or a contractor of the office of Medicaid policy and planning, a licensed child placing agency, and a college or university. I also understand that other entities may be added to this list through amendment to I.C. 16-38-5-3.

I hereby consent to the release of such information.

_____ _____
Printed Name of Parent/ Guardian *Date*

_____
Signature of Parent/Guardian

_____
Child's Printed Name

Career/Success Academy _____
School *Grade*

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