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School and Grade

FORT KNOX COMMUNITY SCHOOLS
Fort Knox, Kentucky

THIS STATEMENT COVERS THE DURATION OF YOUR CHILD'S STAY IN FORT KNOX COMMUNITY SCHOOLS. IF ANY OF THE INFORMATION CHANGES DURING YOUR STAY, IT IS THE SPONSOR'S/GUARDIAN'S RESPONSIBILITY TO INFORM THE SCHOOL OFFICE OR SCHOOL NURSE OF THOSE CHANGES.

STUDENT NAME_____Sex M_____F _____ DATE OF BIRTH_____
Last First Middle Month day Year

Home Address_____Mother's Cell Phone _____Home Phone_____

Father's Cell Phone_____Pager_____

Name of Military Sponsor_____Rank_____Sponsor's Social Security Number_____
Last First Middle

Sponsor's Company_____Sponsor's Duty Phone_____

Spouse Name_____Work Phone_____Home E-mail address_____
Last First

It is IMPERATIVE that we have the phone number (local) of a friend or neighbor who could take charge of your child in case of an emergency and we are unable to reach you.

1. Name_____Home Phone_____Work Phone_____

2. Name_____Home Phone_____Work Phone_____

MEDICAL HISTORY

Please list any physical conditions or limitation your child has such as allergies, heart problems, asthma, epilepsy, diabetes, hearing loss, visual problems, etc.
In order to maintain a safe environment for your child, this information will be shared with those professionals in the school with a need to know.

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MEDICATIONS are given at school only with a doctor's prescription and signed parental permission. They must be delivered to the nurse by a parent and in a pharmacy container with a prescription label. Long term medications must be in a bottle marked "For School Use." Over the counter medications can only be dispensed if they are submitted to the nurse in a new, unopened container and accompanied by a doctor's written prescription. Children may not carry any medications, including over the counter medications, on their person at any time on school grounds. Some students, with special permission, may carry their asthma inhalers or other emergency medications if the doctor deems it necessary and the parent and doctor fill out the necessary forms.

1. Is your child on any **long term** medication(s)? YES_____NO_____

If so, please give the name and dosage of the Medication(s).
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2. Does your student have **asthma**? YES_____NO_____ If yes, does he/she need an inhaler at school? YES_____NO_____

3. Does your child have an allergy to bee/wasp stings? YES_____NO_____

If so, please describe the type of reaction._____Reaction time_____Date of the last reaction_____
Does the reaction require an Epi-Pen? YES_____NO_____
* If your child requires an Epi-Pen, he/she must have his/her own individually prescribed Epi-Pen to be kept in the Nurse's office.

4. Does your child have an allergy to any food? YES_____NO_____If so, please describe the type of reaction.
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Does the reaction require an Epi-Pen? YES_____NO_____
* If your child requires an Epi-Pen, he/she must have his/her own individually prescribed Epi-Pen to be kept in the Nurse's office.

Please see the nurse if this allergy requires the school to make special meals for your child.

I give permission for my child to be given medical care and participate in the programs listed below:

RECEIVE FIRST AID AND EMERGENCY CARE IF NEEDED	YES_____NO_____
SCREENINGS: VISION, HEARING AND SCOLIOSIS (Curvature of the spine)	YES_____NO_____
SCHOOL HEALTH PROGRAM SUCH AS DENTAL HEALTH, HYGIENE, ETC.	YES_____NO_____

PERMISSION FOR EMERGENCY MEDICAL CARE AT IRELAND ARMY COMMUNITY HOSPITAL WHEN A PARENT CANNOT BE REACHED: I give permission to Ireland Army Community Hospital personnel to carry out the procedures which in their professional judgment are necessary in the event that my child _____becomes involved in an accident or suffers from any physical condition in the Fort Knox Community Schools that threatens life or physical ability. I give permission to the school personnel to help secure this care in my absence in the event that I cannot personally be reached.

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Signature of Parent or Guardian- IN INK **Date**