BENTON CENTRAL
JR. - SR. HIGH SCHOOL
4241 E. 300 S.
Oxford, IN 47971
765.884.1600
BC.BENTON.K12.IN.US

"The Mission of BCSC is to ensure all students develop academically, creatively, physically, and socially into the finest version of themselves."

Health History

Complete the following information so that an accurate and updated health record can be maintained for your child.

Student Name: _____ **Grade**:_____ **School Year**: _2019-2020__

Siblings attending Benton Central:

_____

Significant medical history and dates including diseases/disorders/illnesses/conditions (i.e. diabetes, ADHD, hearing loss, vision loss, Irritable Bowel Syndrome, Crohn's Disease, etc.) *Information may be shared with pertinent staff.

_____

_____

_____

_____

Allergies (please list):_____

Severe Allergies that require use of an Epi-Pen: Yes or No **(If yes, complete Allergy Action Plan packet.)**

List all medications taken: (please include prescribed and/or over the counter medications your child takes, along with reason and time)

_____

_____

_____

_____

Last Physical Exam: _____ **Last Eye Exam**: _____

Daytime Emergency Contacts (other than guardian) & Phone Number(s):

1)_____

2)_____

Parent Guardian Signature: _____ **Date**:_____

Please return this form to the Health Center or scan and email to jrichey@benton.k12.in.us

BENTON CENTRAL
JR. - SR. HIGH SCHOOL
4241 E. 300 S.
Oxford, IN 47971
765.884.1600
BC.BENTON.K12.IN.US

"The Mission of BCSC is to ensure all students develop academically, creatively, physically, and socially into the finest version of themselves."

Over-the-Counter As Needed Medications

Student Name: _____ **Grade**:_____ **School Year**: _2019-2020__

STOCK SUPPLY IS KEPT IN THE HEALTH CENTER

_____ **Non-Aspirin Pain Reliever (Acetaminophen/Tylenol)** _____ **1 or** _____ **2 tabs (325mg)**

_____ **Ibuprofen (Anti-Inflammatory)** _____ **1 or** _____ **2 tabs (200mg)**

_____ **Antacid Tablets (Tums)**

_____ **Chloraseptic Throat Spray**

I request that school personnel administer the medication(s) that are **checked** to my child during school hours should he/she need it. I have noted any special instructions below.

Parent Guardian Signature: _____Date:_____

Please return this form to the Health Center or scan and email to jrichey@benton.k12.in.us

BENTON CENTRAL
JR. - SR. HIGH SCHOOL
4241 E. 300 S.
Oxford, IN 47971
765.884.1600
BC.BENTON.K12.IN.US

"The Mission of BCSC is to ensure all students develop academically, creatively, physically, and socially into the finest version of themselves."

Prescription Medication To Be Given at School

School Year: 2019-2020

Indiana Law IC 34.4-16.5 3.5 of Indiana Tort Claims Act allows the school nurse or other designated school personnel to assist students who are required to take medications during the school day. This service is provided to enable the student to remain in school and to maintain or improve the potential for learning.

ALL MEDICATIONS MUST BE IN THE ORIGINAL CONTAINER LABELED WITH THE STUDENT'S NAME

Student Name: _____ **Grade**:_____

Allergies: _____

Name of medication:_____

Dosage/Time to be given:_____

Reason:_____

Special Instructions:_____

It is necessary for the above medication to be taken during the school day. Therefore, I request that school staff members administer the medication to my child during the school day in accordance with the above written instructions. I also give my child permission to transport his/her medication to Benton Central Jr/Sr High School. At the end of the school year or sooner, all medications will be returned to the student and should be taken home.

Parent Guardian Signature: _____**Date**:_____

Please return this form to the Health Center or scan and email to jrichey@benton.k12.in.us

BENTON CENTRAL
JR. - SR. HIGH SCHOOL
4241 E. 300 S.
Oxford, IN 47971
765.884.1600
BC.BENTON.K12.IN.US

"The Mission of BCSC is to ensure all students develop academically, creatively, physically, and socially into the finest version of themselves."

CHIRP Form

I,_____, give Benton Central Jr./Sr. High School, permission to release the following information concerning my child _____ to the Indiana State Department of Health's Children and Hoosier Immunization Registry Program (CHIRP):

> Name, immunization data, date of birth or other identifying information, parent/guardian name and address as applicable.

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

I understand that my child'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 contractor of the office of Medicaid policy 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.

_____ _____
Signature Date

_____
Printed Name of Parent or Guardian

_____ ( )_____
Address Phone

_____ _____
Child's Name Grade

_____
School

Please return this form to the Health Center or scan and email to jrichey@benton.k12.in.us