SISSETON SCHOOL DISTRICT 54-2

Health & Emergency Medical Release Form

Please complete each section thoroughly, sign and date.

Student's Name: _____ **Sex:** F ☐ M ☐
Last First

Birthdate: _____ **Age:** _____ **Grade Level** _____ **Address** _____
MM/DD/YY

Allergies: Does your child have any allergies to food, medications, insects, etc.? ☐ Yes ☐ No

If Yes, please list: _____

Does your child require an Epinephrine Pen for this allergy? ☐ Yes ☐ No

Health Conditions: Has your child, currently or in the past, been diagnosed with any of the following health conditions (Check all that apply):

Asthma	☐ Yes	☐ No	Epilepsy/Seizure Disorder	☐ Yes	☐ No	Vision/Hearing Problems	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Frequent/Migraine Headaches	☐ Yes	☐ No	Chronic Ear Infections	☐ Yes	☐ No
Heart Problems	☐ Yes	☐ No	Attention Deficit-Hyperactivity	☐ Yes	☐ No			

If Yes, please explain: _____

List any other health condition(s) not listed above: _____

List any ***medication(s)*** currently taken by your child: _____

***In the event that a student needs medication during school, the parents/guardians must contact the school nurse/personnel to complete required protocol. See medication policy.**

Name of Child's Physician _____ Address _____

Name of Child's Dentist _____ Address _____

In case of emergency, take my child to the following hospital:

☐ _____

Person authorized to pick up my child and/or to contact in case of an illness or an emergency (other than parents):

Name: _____ **Relationship** _____ **Phone Number** _____

Name: _____ **Relationship** _____ **Phone Number** _____

EMERGENCY RELEASE

If, in the judgment of any responsible person employed by Sisseton School, the student named above needs immediate care and treatment as a result of any injury or sickness, I do hereby request, authorize and consent to such care and treatment as may be given to said student by any medical personnel or school representative. I do hereby agree to indemnify and hold harmless The Sisseton School and any school representative from any claim by any person whomsoever on account of such care and treatment of said student.

_____ _____
Signature of Parent/Guardian Date

According to SD Law SDCL 13-28-7.1 and 13-27-3.1 all students enrolling in a South Dakota School are required to present a copy of their

IMMUNIZATION RECORD AND CERTIFIED BIRTH CERTIFICATE.

Minimum Immunization requirements are:

1. Four or more doses of DPT Vaccine with at least one dose given after age 4.
2. Three or more doses of Polio Vaccine with at least one dose given after age 4.
3. Two doses of Measles, Mumps & Rubella given after the age of 1.
4. Two Varicella Vaccine or history of having the Chicken Pox.

KINDERGARTEN STUDENTS must provide the above information to the school prior to the first day of attendance or they **WILL BE** sent home.

Students transferring from another school must have these immunizations completed and a copy on file at the school within **30 Days** or your child will not be allowed to remain in school. They **WILL BE** sent home.

I understand the above information and will provide the school with the required documents within the **specified time** or my child will not be allowed to attend Sisseton Public School.

_____ _____
Signature of Parent/Guardian Date