Medical Information and Release Form

School Year: _____

This shall remain in effect as long as my child attends Yellville-Summit Schools.

Student Name:_____Grade:_____

Physicians Name:_____

Does student have a *current* medical diagnosis of any of the following conditions?

__ADD/ADHD	__Hearing Loss L/R	__Wear Contacts/Glasses
__Anxiety	__Hearing Aid L/R	__Nose Bleeds
__Asthma	__Heart Condition	__Bladder Problems
__Depression	__Migraine Headaches	__Bowel Problems
__Diabetes	__Seizures	__Pregnant

Other (Specify)_____

What medication(s) is your child currently taking?_____

_____

Severe or Life-threatening allergies to: Foods, Nuts, Latex or Stings (Specify)_____

_____

(YOU MUST SUPPLY THE SCHOOL WITH BENADRYL AND/OR EPI PENS)

(If a student is to carry an inhaler, epi pen or diabetic supplies, there must be a medication form filled out as well as a note from their medical doctor on file with the nurse. These forms must be renewed **annually by their Doctor**. These are the only medications that a student may carry on their person.)

I will notify the school of any change in address, phone number, emergency contact or said child's health status. I understand that the above information may be released to appropriate School District employees, named physicians, and emergency personnel. In the event of an emergency and/or that parents or other person(s) named on this form cannot be contacted, the school officials are hereby authorized to take whatever action is deemed necessary in their judgment, for the health of the aforesaid child. I will not hold the school district financially responsible for the emergency care and/or transportation for said child. I authorize the school nurse and my child's health care provider to exchange verbal and/or written information regarding the health needs of said student at school.

I acknowledge that the Yellville-Summit School District, the Board of Directors, and School Employees shall be immune from civil liability for damages resulting from the administration of medications in accordance with this consent.

In compliance with the Family Education Rights and Privacy Act (FERPA) (20 U.S.C. § 1232g; 34 CFR Part 99) I give permission for my child's personally identifiable information/student education records to be disclosed to ISEP For the purpose of billing Medicaid and/or private insurance.

If applicable, do you give permission for **Medicaid/ARKids** to be billed if necessary? _____**Yes** _____**No**

Date:_____**Signature of Parent/Guardian**_____

(PLEASE MARK THROUGH ANY MEDICATION YOU MAY NOT WANT YOUR CHILD TO RECEIVE)

You are authorizing the use of:

Generic Tylenol, Ibuprofen, Midol Complete (for cramps)
Zyrtec (for allergies) Benadryl (for allergic reaction) Allergy Relief Eye Drops
TUMS Pepto
Caladryl Clear First Aid Spray - Bactine Triple Antibiotic Ointment Anti-itch Cream Anti-Sting Icy Hot Cooling Burn Gel
Cough Drops Anbesol (for toothache) Peroxyl (for mouth sores) Lip Balm

Date:_____Signature of Parent/Guardian:_____

Updated 08/18/2026