

North White School Corporation

Bowel Issues

School Year: _____

Student Name: _____	Grade: _____
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Parent/Guardian Name: _____	Phone#: _____
Parent/Guardian Name: _____	Phone#: _____
Emergency Contact: _____	Phone#: _____

Diagnosis: _____

Symptoms: _____

Current Treatment: _____

Will student need to take medications at school? ☐ YES ☐ No If yes, name of medication and how often _____

Any possible side effects from medications we need to be aware of? ☐ Yes ☐ No *If yes, please list: _____

Will student require any accommodations? ☐ Yes ☐ No ****Healthcare provider note required for all accommodations, including open bathroom privileges.**

I understand that it is my responsibility to keep this information current and to provide an updated form on at least an annual basis. I agree to maintain an adequate supply of medication at school if needed. I give permission for school personnel, who volunteer under no duress and are trained by a Registered Nurse, to participate in the care of my child in the event a school nurse is not present. I give permission for the school nurse to share this information with other school personnel on a need to know basis.

Parent/Guardian Name Printed: _____

Parent/Guardian Signature: _____ Date: _____