North White School Corporation
Urinary Issues

School Year:_____

Student Name:_____	**Grade**:_____

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:_____