STUDENT HEALTH INFORMATION

Student's Name_____ Date of Birth_____ Grade_____

Mother's/Guardian's Name _____Home# _____Work #_____

Father's/Guardian's Name _____Home# _____Work #_____

Emergency Contact (Other than parent) _____Home# _____Work #_____

Physician_____Office #_____

Dentist _____Office #_____

Specialist_____Office #_____

Please answer the following questions:

Is your child on any prescription medications that will need to be given at school? *If YES, a medication form must be completed and signed by the health care provider or practitioner. Medication and health plans must be updated yearly*	☐Yes ☐No
Has your child seen the doctor for a wellness check within the past 12 months?	☐Yes ☐No
Has your child ever stopped breathing?	☐Yes ☐No
Has your child ever needed CPR?	☐Yes ☐No
Has your child ever needed the Heimlich Maneuver (emergency response) for choking?	☐Yes ☐No
Has your child been diagnosed with a concussion in the last year?	☐Yes ☐No
Has your child ever been hospitalized for any condition(s) checked? If yes, list condition and date(s) below	☐Yes ☐No

_____

In order to assure optimal student performance at school and promote good health, wellness screenings may be conducted on a regular basis. Referrals to appropriate health care providers will be made for students needing further evaluation. School nurses and interns have guidelines to follow for the care of students on campus. Medications will only be given according to the doctor's written direction with parent permission. School officials do **not** have a supply of over-the-counter medications to give to students. Students with life threatening allergies to bee stings, foods or latex will need his/her doctor to provide a written authorization for the injectable medicine (Epi-Pen) to be stored at school and/or carried by student. However, should a student have a sudden, undiagnosed, serious life-threatening reaction (anaphylaxis), 911 and the parent/guardian will be notified.

Please contact the principal or school nurse if you have any questions.

_____ ____/_____/20___

Signature Parent/Guardian **Date**

PLEASE COMPLETE THE REVERSE SIDE OF THIS FORM BEFORE RETURNING. *To opt out of any health screening, contact your child's school nurse.

STUDENT HEALTH INFORMATION

STUDENT HEALTH HISTORY

Does your child have any of the following diseases or disorders? (Check all that apply)

☐ MY CHILD DOES NOT HAVE ANY HEALTH CONDITIONS

Endocrine disorders ☐ Diabetes: Requires insulin- ☐Yes ☐No ☐ Hormonal ☐ Thyroid ☐ Other _____ ☐ Medication_____	**Lungs/Respiratory disorders** ☐ Asthma ☐ Medication_____ ☐ Inhaler/nebulizer used last 2 years ☐ Other_____	**Heart Condition** ☐ High Blood Pressure ☐ Irregular Heart Rhythm ☐ Medication_____ ☐ Other _____
Allergies ☐ Life threatening ☐ Bees ☐ Food-list _____ _____ Requires Epi-pen- ☐Yes ☐No ☐ Non-life threatening ☐ Seasonal/Environmental ☐ Other_____	**Head/Neurological** ☐ ADD/ADHD ☐ Cerebral Palsy ☐ Asperger syndrome ☐ Autism ☐ Migraines ☐ Seizures ☐ Traumatic Brain Injury (TBI) ☐ Shunt ☐ Other_____ ☐ Medication _____	**Cancer** ☐ Type_____ ☐ Date Diagnosed_____ Restrictions- ☐Yes ☐No Describe_____
Blood Disorder ☐ Anemia ☐ Hemophilia ☐ Sickle cell disease ☐ trait ☐ Thalassemia	**Bone/Joint** ☐ Lupus ☐ Use crutches, braces, walker, wheelchair ☐ Other _____	**Behavioral/Emotional** ☐ Anxiety ☐ Bipolar disorder ☐ Depression ☐ Eating disorder ☐ OCD/ODD/PTSD ☐ Other _____
Gastrointestinal ☐ IBS/Irritable Bowel/Crohn's Disease ☐ Other_____	**Ears** ☐ Hearing Impaired Describe_____ _____ Requires hearing aids- ☐Yes ☐No	**Eyes** ☐ Vision impaired ☐ Glasses/Contacts- ☐Yes ☐No ☐ Other _____
Food Modifications _____ _____ _____	**Routine Medications** _____ _____ _____	**Other Conditions** _____ _____ _____

_____ Date_____/_____/20_____

Parent/Guardian Signature

SCHOOL NURSE USE ONLY

☐Medication Authorization Form to Parent

_____

RN Signature/Date

☐Diet Order Form to Parent

_____

RN Signature/Date

☐Follow Up Completed

_____

RN Signature/Date

☐EAP Posted

_____

RN Signature/Date

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