

Student's Last Name: _____ First Name: _____

Date of Birth: _____ Grade: _____ School Year: _____

STUDENT HEALTH CONDITIONS

Check all boxes that apply to the student.

ALLERGIES Yes No

Allergy Type:

- Food List food(s): _____
- Medication List medication(s): _____
- Bee stings or insect bites
- Other: _____

Date of last severe reaction: _____

Date of last hospital or emergency room visit due to allergies: _____

Currently prescribed medications and treatments for allergies:

- Oral antihistamine (Benadryl, etc.)
- Epinephrine Has Epi-Pen
- Other: _____

FOOD RESTRICTIONS Yes No

- Due to Gastrointestinal (Digestive) distress List food(s): _____
- Due to religious or other preferences List food(s): _____

ASTHMA Yes No

Currently prescribed medications and treatments for asthma:

- Daily control (prevention) medication
- As needed (rescue) medication

Date of last hospital or emergency room visit due to asthma: _____

DIABETES Yes No

Date of last hospital or emergency room visit due to diabetes: _____

Does the student's diabetes require medication and/or blood testing IN SCHOOL?

- No
- Yes List medication(s): _____

SEIZURE DISORDER Yes No

Does the student's seizure disorder require medication IN SCHOOL?

- No
- Yes List medication(s): _____

Date of last seizure: _____

Date of last hospital or emergency room visit due to seizure: _____

OTHER HEALTH CONDITIONS Yes No

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Obstructive Sleep Apnea | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Nutritional Disorder | <input type="checkbox"/> Chronic Infection (Hepatitis C, HIV) |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Sickle Cell Disease | <input type="checkbox"/> Physical Disability | <input type="checkbox"/> Congenital/Chromosomal Disorders |
| <input type="checkbox"/> Developmental Delay | <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Eczema | <input type="checkbox"/> Depression |

Other physical or mental health conditions: _____

Does the student's condition require IN SCHOOL USE of the following?

Medications: No Yes List medication(s): _____

Special procedures: No Yes List procedure(s): _____

Special equipment: No Yes List equipment: _____

VISION CONDITIONS Yes No

- Glasses
- Contacts
- Non correctable
- Other: _____

HEARING CONDITIONS Yes No

- Hearing aid(s)
- Non correctable
- Other: _____

STUDENT HEALTH CARE AND HEALTH COVERAGE

Does the student have health insurance? No Yes Name of health insurance company: _____

Name of student's primary care doctor: _____ Phone: _____

Does the student have dental insurance? No Yes Name of dental insurance company: _____

Name of student's dentist: _____ Phone: _____

PARENT/GUARDIAN AUTHORIZATION

In the case of an emergency, school staff will call 911. Every attempt will be made to contact a parent, legal guardian or emergency contact. Students will be transported to the nearest Emergency Room unless the parent is on the school premises to assume responsibility for the child.

The parent/guardian is responsible for providing the school with any medication, special food, supplies, or equipment that the student requires during the school day. Check with the school nurse or registrar to obtain correct medication and procedural forms. If an individual school health care plan is indicated, the parent/guardian is responsible for providing the school nurse with necessary medical information, appropriate authorization forms and written consent to exchange information with the child's physician.

I, _____ (do___) (do not___) authorize my child's health care provider and designated provider of health care in the school setting to discuss my child's health concerns and/or exchange information pertaining to this form. *This authorization will be in place until or unless you withdraw it. You may withdraw your authorization at any time by contacting your child's school. When information is released from your child's record, documentation of the disclosure is maintained in your child's health or scholastic record.*

Parent/Guardian Signature: _____ Date: _____