

STUDENT HEALTH INFORMATION- SCHOOL YEAR

Student's Name _____ School _____ Teacher _____ Gr. _____

Birthdate _____ Parents/Guardian's Name: _____ Phone _____

Emergency Contact _____ Phone# _____

Family Doctor's Name _____ Address _____ Phone _____

Does the student wear glasses or contacts? _____ Have hearing aids? _____

Does your child have any of the following? Yes _____ (Check in box and complete all that apply.) No _____
(If answered no, go to bottom of page, sign, date, and return to your child's school.)

<p>Asthma Age of diagnosis _____</p> <p>What causes asthma attacks _____</p> <p>Name of Regular Asthma Medication _____</p> <p>Name of emergency medication (Inhaler) _____</p> <p>Does student need help with inhaler? _____ Will student keep inhaler with him/her at school? _____ or leave with the school secretary or nurse? _____</p> <p>Nebulizer @ home _____ Nebulizer @ school _____</p> <p>Does student have a Peak Flow Meter? _____ Has doctor completed an Asthma Action Plan for school? _____</p> <p>Name of Doctor treating asthma _____</p> <p>Phone Number () _____</p> <p>Expiration Date on Inhaler _____</p>	<p>Heart Type of Heart Problem _____</p> <p>Diagnosed at what age _____ Medication _____</p> <p>Does the student require antibiotics before dental work? _____ If yes, what medication and what dosage? _____</p> <p>Any restrictions on activities? _____</p> <p>Last doctor's visit for heart problem _____</p> <p>List signs/symptoms which require emergency action and what actions should be taken. _____</p> <p>Name of Doctor treating heart problem _____</p> <p>Phone Number () _____</p>
<p>SEVERE ALLERGY TO:</p> <p>Food Name of food _____ Reaction _____</p> <hr/> <p>SEVERE ALLERGY TO:</p> <p>Insect Bites/ Stings</p> <p>Itching & swelling of lips, tongue or mouth _____</p> <p>Itching of throat _____ Itchy rash, welphs _____</p> <p>Difficulty breathing _____ Nausea, vomiting, diarrhea _____</p> <p>SWELLING AT STING/BITE SITE ONLY?</p> <p>Is an Epipen prescribed for school use? _____</p> <p>If so, what is the expiration date on Epipen? _____</p>	<p>Diabetes _____ Type I _____ Type II Age of Diagnosis _____</p> <p>Insulin @ school. Type of insulin _____</p> <p>Pump _____ Type of insulin _____</p> <p>Blood Glucose checks @ school _____</p> <p>Check Ketones @ school _____</p> <p>Glucagon ordered? If so, what is the expiration date? _____</p> <p>Is student on a sliding scale? _____</p> <p>Have you provided a container of snacks for school and bus to treat low blood sugar? _____ This is strongly recommended.</p> <p>Name of Doctor treating diabetes _____</p> <p>Phone Number () _____</p>
<p>Is student allergic to medication(s)? _____ Which one? _____</p> <p>Describe reaction. _____</p> <p>Allergy to Latex Reaction _____</p> <p>High Blood Pressure (Age diagnosed _____)</p> <p>Medication for high blood pressure _____</p> <p>Migraine Headache (Medication _____)</p> <p>ADD _____ ADHD Medication _____</p> <p>Does this medication have to be given at school? _____</p> <p>When was ADD or ADHD diagnosed? _____</p> <p>Hemophilia _____ Sickle Cell Anemia _____ Shunt _____</p> <p>Other Health Problems _____</p>	<p>Seizures/Epilepsy Age of Diagnosis _____</p> <p>Type of Seizures _____</p> <p>What causes Seizures? _____</p> <p>Date of last seizure _____</p> <p>Medication _____ Dosage _____</p> <p>Length of Seizures _____</p> <p>What happens before and during a seizure _____</p> <p>Is any emergency medication (Diastat) ordered for school use? _____</p> <p>Expiration Date for Diastat _____</p> <p>Name of Doctor treating seizures _____</p> <p>Phone Number () _____</p>

List medications student takes regularly at home _____

Is it necessary that any medications be taken at school? _____ If so, what? _____

If medications must be taken during school hours, a medication authorization form (available at school) must be completed by the parent AND the physician each school year.

If this student's health conditions or medication(s) change during the school year or if you have questions or comments please contact your child's school.

I understand this information will be kept at school, and a copy will be given to the School Nurse. Other school personnel will be given this information on a need to know basis. I authorize the School Nurse to talk with the physician should a question come up regarding this student's health information.

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

