STUDENT HEALTH INFORMATION- SCHOOL YEAR

Student's Name_____School_____Teacher_____Gr._____

Birthdate_____Parents/Guardian'sName:_____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.)

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

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:_____