HERRON HIGH SCHOOL
HERRON-RIVERSIDE HIGH SCHOOL
HERRON PREPARATORY ACADEMY

HEALTH INFORMATION FORM

ESKENAZI HEALTH

Grade: _____

Student's Full Legal Name: _____ **Date of Birth:** _____ / _____ / _____

Prefers to be called: _____ **Sex:** _____ **Race:** _____

Student's home address: _____

Student's Cell #: _____-_____-_____ **Student's E-mail:** _____@_____.____

Primary Care Physician: _____ **Which hospital do you prefer?** _____

Is your child currently under treatmentnfor a medical condition? Y or N Please explain: _____

Does your child have ANY allergies to Medicines? Y or N List: _____

Does your child have ANY food allergies? Y or N List: _____

Is your child allergic to Bee Stings? Y or N **Does your child have seasonal allergies? Y or N**

Do they have an EPIPEN? Y or N Is the EPIPEN on them at all times? Y or N What do you give them for a reaction? _____

Is your child taking any medications? Y or N If Yes, List below, including natural remedies and any over-the-counter medications:

Medication Name	Dosage	Frequency of Use

Has your child ever had surgery or been hospitalized? Y or N If Yes, List below:

Hospital	When (M/YR)	Reason
	_____ / _____	
	_____ / _____	

Does your child have/ or had any of the following: Check all that apply

- ☐ Asthma/ Breathing problems:
  - Do they have/ use an inhaler? Y or N
  - Do they carry it at all times? Y or N
  - Do they have a Asthma Action Plan? Y or N
- ☐ Abnormal Bleeding Issues: Problem: _____
- ☐ ADD/ ADHD
- ☐ Anxiety
- ☐ Autism
- ☐ Cerebral Palsy
- ☐ Depression
- ☐ Lactose Intolerance
- ☐ Concussion: When/ How?:
- ☐ Congenital Heart Defect/ Disease/ Heart Murmur
- ☐ Diabetes: Type 1 or 2 / Insulin Dependent? Y or N
  - Do they manage it on their own? Y or N
- ☐ Eating Disorder:
- ☐ High Blood Pressure
- ☐ Learning/ Communication Problems
- ☐ Mental Health issues:
- ☐ Seizures/ Convulsions/ Epilepsy
- ☐ Sickle Cell Trait or Sickle Cell Disease
- ☐ Migraines
- ☐ OTHER:
- ☐ OTHER:

Parent/ Guardian Information: Who does student live with? _____MOM _____DAD _____Grandparent _____OTHER: _____

Mother- LEGAL Guardian Yes or No

Name: _____ Date of Birth: _____/_____/_____ Cell #: _____-_____-_____

Work Name: _____Work #: _____-_____-_____ E-mail: _____@_____.____

Father- LEGAL Guardian Yes or No

Name: _____ Date of Birth: _____/_____/_____ Cell #: _____-_____-_____

Work Name: _____Work #: _____-_____-_____ E-mail: _____@_____.____

EMERGENCY CONTACTS - *Who can pick your child up from school, in the situation you can't.*

Name_____ Phone: _____-_____-_____ Relationship: _____

Name_____ Phone: _____-_____-_____ Relationship: _____

Your signature below will allow the schoolhealthcare office or designated personnel to give, from the emergency supply on hand, the following over-the-counter (OTC) medications on an as-needed basis. If your child requests these medications frequently, you will be required to provide the medication needed. OTC medications of any kind will not be given for more than 7 times per school year.

PLEASE MARK AN "X" or "Y" ON EACH MEDICATION, INDICATING "YES" my child can be given this medication.(Name Brand in parentheses)

YES	OTC MEDICATION	GIVEN FOR
	Acetaminophen (Tylenol)	Headache, Fever, Toothache
	Ibuprofen (Advil / Motrin)	Menstrual Cramps, Body aches, Inflammation, Pain
	Diphenhydramine (Benadryl)	Allergic Reactions, Severe Itching, Rash, Allergies
	Antacid (Tums / Rolaids)	Heartburn, Stomach Ache, Indigestion
	Calamine Lotion-drying lotion	Rash from Poison Ivy, Insect Bites
	Hydrocortisone Cream-anti-itch	Itchy Rash, Skin Irritations

I affirm that the information provided above is correct to the best of my knowledge. I understand it will be held in confidence and it is my responsibility to inform the school healthcare office of any changes in my childs health.

Parent/Guardian Print Name: _____

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