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| **Norwood Public School District****Health Inventory and Parent Information** |
| ***Please fill out this form at the start of each school year******Please call the district school nurse at (970)327-4336 x129 with any questions or concerns*** |
| **GRADE: SCHOOL:** Norwood Public Schools |  | **New student** |  | **Returning** |
| **Student Name: , , ( )****LAST FIRST MIDDLE NICK NAME** |
| **Date of birth: Gender:** |  | **M** |  | **F** |  | **Other:** |
| **Parent/Guardian Name: Phone:** |
| **2nd Contact Name: Phone:** |

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| **SECTION 1: PROVIDER INFROMATION** |
| **Doctor/Provider: Phone:** |
| **Dentist: Phone :** |
| **Optometrist: Phone:** |
| **Orthodontist: Phone:** |
| **Other: Phone:** |
| **Date of Last Physical** |

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| **SECTION 2: HEALTH PROBLEMS/HEALTH ISSUES****Please check health problems your child has now – OR – has had in the past:** |
| **Check this box if NO changes from last year** or if your child does not have any medical issues. Please do not check if your child takes daily medications, has any chronic illnesses, new injuries like fractures – especially concussions, or recent surgeries or hospitalizations. It is important for the nurse's office to have an -to-date health history every year. **If you check this box, you can skip to Section 3.** |
|  | Allergies (Section 5)Anaphylaxis (Section 5)Asthma (Section 5) Attention Disorder ADD/ADHDBirth weight less than 5 poundsBlood Disease Bone/Joint Disease Bronchitis – frequent CancerCeliac disease Concussion/head injury (Section 5)Dental Issues/ Braces Developmental Diabetes/hypoglycemia(Section 5) |  |  | isabilities Eating/Weight Problems Ear Infections/Earaches EczemaEmotional Issues Gastrointestinal/Urinary Glasses/contacts HeadachesHearing Loss/hearing aids (Section 5)Heart Condition/blood pressuremmune problems njuries - significant | Intestinal/bowel issues Menstrual Issues Mental Health Issues Nose bleedsPhobias Pneumonia Seizures (Section 5) Skin problems Sleeping ProblemsStrep Throat- frequent Substance abuse issues Surgery/operations VisionOther:  |

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| **If you have checked any of the above, please describe and explain:** |

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| **SECTION 3: MEDICATIONS** |
| **Does your child take medications?** Daily As Needed Prescription Over the CounterPlease List all medications: Include Medication Name, Dosage and Times given at home and/or at school:1.
2.
3. Does Your child need Medications at School? Yes NO

If yes, the Provider and Parent must sign the permission to give medication form.**EMERGENCY MEDICATIONS:****EPINEPHRINEEPHRINE AUTOINJECTOR INHALER BENADRYL SEIZURE MEDICATION OTHER:** If your child is 12 years or older and you would like them to have over the counter medications if needed at school, please fill out the OTC Permission Form. |

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| **SECTION 4: MEDICAL HISTORY** |
| Has your child had chicken pox in the past? Yes No If yes -when? Has your child had tuberculosis in the past? Yes No If yes -when?  |
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| **SECTION 5: ADDITIONAL MEDICAL INFROMATION****If your child has any of the following issues, please fill out appropriate sections and forms.** |
| **Allergy & Anaphylaxis** | **To Drugs, Food, Insects (include beestings), pollen, seasonal? Please list**:**Describe Reactions:** * **Has the allergy required emergency action in the past?** Yes No
* **Has the allergy caused difficulty breathing?** Yes No
* **Does your child use an Epinephrine autoinjector?** Yes No
* **Does your child have asthma?** Yes No

**Note:** Self-carry contract is required for ALL students before carrying their own epinephrine. Only school nurses may approve. Also, have your child’s provider fill out the [Emergency Allergy &](https://www.cde.state.co.us/healthandwellness/standardanaphylaxisplan2016) [Anaphylaxis Care Plan](https://www.cde.state.co.us/healthandwellness/standardanaphylaxisplan2016) if your child has severe allergy, anaphylaxis or requires an epinephrine autoinjector. Both you and your provider must sign. Contact the school nurse for informationabout our in-stock epinephrine emergency procedures. |
| **Asthma** | **Diagnosed by Doctor**  |

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| **Reactive Airway** | **Date Last Episode Triggers:** **Does Student Require medication to be given at School?** Yes No**Does the Student Require a Spacer with an inhaler?** Yes No**Note:** Please have your provider fill out the [Colorado Asthma Care Plan](https://www.cde.state.co.us/healthandwellness/coloradoasthmacareplan) and provide a copy to the school nurse. Both you and your provider must sign.* Grades 5 – 12 May self-carry inhaler IF approved by nurse and provider. Note: Self-carry contract is required for ALL students prior to carrying their own emergency inhaler.
* A back up inhaler for the Nurse’s office is recommended. Contact the school nurse about our in-stock albuterol inhaler emergency procedure.
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| **Diabetes Hypoglycemia** | **Date Diagnosed:** **Paperwork (DMMP) from Barbara Davis Center (or other) to School Nurse?** Yes No |
| **Take Insulin? Self-regulated?****Pump/self-inject?** |  | Yes YesYes |  | No NoNo |
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| **Other:** **Glucagon:** |  |  |  |  |
| **Self- carry?** Yes**In nurses room?** Yes**Extra Supplies to nurse?** Yes |  | No No No |
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| **Note:** Contact Nurse for additional information |
| **Dietary****Nutritional Celiac** |  |  | **Celiac disease** |  |  | **Food intolerance** | **Special considerations:** |
| **Lactose****intolerance Gluten****intolerance** | **Food Allergy (go to Allergy)** |
| **Headache Migraine** | **Does your child require medication at school?** |  | Yes |  | NoNo |
| **If yes, medication form filled out?** Yes |  |
| **How frequently does your child get headaches? Seen by doctor?** **Additional Information:** [**Migraine and Chronic Headache Care Plan (Children's Hospital Denver)**](https://www.cde.state.co.us/healthandwellness/childrenshospitalcoloradoheadacheactionplan) |
| **Head Injury Concussion** | Has your child had a head injury/concussion? |  | Yes |  | No |
| If yes, when? N Does your child have any physical restrictions? | umbe | r: Yes |  | No |
| Academic accommodations? |  | Yes No |
| **Hearing Issues** | Known hearingloss Frequentinfections | Hearing concerns | : |  | Hearing Aids: Yes No |
| Preferential seating |  |  | Right LeftOther:  |
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|  |  | Tubes 504 plan |  |  |  |
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| **Heart Issues** | Describe: List Physical Restrictions:  |

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|  | **Note**: Please contact the school nurse for chronic health issues associated with your child’scondition |
| **Seizure/Epilepsy** | Describe: Date last seizure: Currently under doctor's care? Yes NoMedications: Required at school? Yes No**Note**: Please fill out the [Emergency Seizure Action Plan](https://www.cde.state.co.us/healthandwellness/seizureactionplanandmedicationorders-wordmay2019) and return to the school nurse. |
| **Special Services** | Special Health Care: (explain) | Special Education Services Speech/Language |  |  |  | Counselor Title IOther:  |
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|  |  | OT/PT |
| **Vision** |  |  | Glasses Contacts Preferential |  |  | Reading Distance Difficulty seeing |  |  | Injury Lazy eyeOther:  |
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| seating |  |  |

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| **SECTION 6: HEALTH INSURANCE** |
| **Do you have health insurance for your child?** Yes No**Private CHP+ Medicaid** **If your child does not have health insurance, do you grant the school district Nurse permission to share this information with Medicaid/CHP+ enrollment counselor?** Yes No |

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| **IMMUNIZATION AND INFECTIOUS DISEASE INFORMATION** |
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| **IMMUNIZATION INFORMATION** |
| Colorado Law requires students who attend a public-school grades kindergarten to 12th grade to be vaccinated against many of the diseases that vaccines can prevent unless there is an exemption form signed.**Note:** If we do not receive appropriate paperwork at the start of the school year your child may be excluded from attending school. We must receive either.More [Information for Immunizations that are required by the State of Colorado](https://drive.google.com/file/d/1OgXagAK5cdd01f6L994xUJQ9Q-LeehVU/view) |
| **MEDICAL EXEMPTIONS** |
| Have your provider fill out the [Medical Exemption Form](https://drive.google.com/file/d/1PnMIMIP8j0exYai6-sF9AW4vkzRMeL6F/view). This form only needs to be filled out once unless theinformation changes. |
| **NON-MEDICAL/PERSONAL EXEMPTIONS** |
| There are two ways to submit a nonmedical exemption. **This must be filled out yearly prior to the start of school.**TSD requires a printed copy of the Certificate of nonmedical exemption. If you submit to CIIS, the school can access the exemption information in CIIS, but cannot access the completed Certificate of nonmedical exemption* Submit the Certificate of nonmedical exemption WITH a signature from an immunizing provider in Colorado who is a medical doctor, Doctor of Osteopathic Medicine, advanced practice nurse, delegated physician’s assistant, registered nurse, or pharmacist OR
* Submit the Certificate of nonmedical exemption received upon completing ion of [CDPHE’s Online](https://www.dcphrapps.dphe.state.co.us/storyline360/story.html)

[Immunization Education Module.](https://www.dcphrapps.dphe.state.co.us/storyline360/story.html) Please send or bring a copy of this to the school nurse’s office.* Parents of students in preschool or childcare must submit nonmedical exemptions at 2, 4, 6, 12 and 18 months of age. These exemptions expire when the next vaccines are due or when the child enrolls in kindergarten.
* Parents of students in grades K-12 claiming a nonmedical exemption must submit one annually. Nonmedical exemptions expire June 30th each year. If you submit a Certificate of nonmedical exemption on or before June 30th, it will not be valid for the upcoming school year unless you submit the exemption during early registration.
* **Fill out the** [**Non-medical/Personal Exemption Form**](https://drive.google.com/file/d/1UdHc39zCBmuyeBBjxShHa15mG-Ea9yFG/view) **and send it to the school nurse before the start of school. we do not receive**
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