SCHOOL NURSE SCREENING AND EMERGENCY CONTACT
Return to School Nurse ASAP

STUDENT'S NAME: _____ Date of Birth_____

Teacher:_____ Grade:_____ Bus #_____ __am__ pm Car:__ am __pm
Prime time: Yes No

Student's Physician_____ Phone #_____ Dentist: _____

Health screening and observation of students K – 12 are legal responsibilities charged to teachers and school nurses. I understand that my child may participate in routine screening such as height, weight, vision, hearing, dental, Communicable Disease's and blood pressure.

It is important that the school be aware of any special health problems your child has. Please check and explain conditions below. ***Check if your child will need Emergency Plan at school.

***If your child needs any medications while at school (prescription and/or non-prescription) you must have a Dr's order on the "REQUEST FOR MEDICATION TO BE GIVEN DURING SCHOOL HOURS" form.**

EMERGENCY NUMBERS

List in order to be called

Name	Relationship	Daytime #
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

☐ **Allergic** to: _____
Does your child need an Emergency Action Plan? Yes or No

☐ Medicine needed at school? Yes or No
Name of Medicine: _____

☐ **Asthma** Medicine:_____
Does your child need an Emergency Action Plan? Yes or No

☐ Inhaler needed at School: Yes or No
Date of last attack: _____

☐ **Diabetes**
Insulin: _____
Pump or Injections (circle)
Pill: _____
Glucagon ordered: Yes or No

☐ **Bleeding Disorder**: (type) _____

☐ **Gastrointestinal** _____

☐ **Special Diet Order** Yes or No

☐ **Kidney Problem:** _____

☐ **Heart Problem**: Describe:_____
_____
Restrictions: _____

☐ **Migraine Headaches** Yes or No

☐ Medication needed at School: Yes or No
Action plan needed? Yes or No

☐ **Orthopedic (Bone) Problem**
Describe: _____
Restrictions: _____

☐ **Seizures(type)** _____

☐ Does your child need an Emergency Action Plan? Yes or No
Date of last seizure: _____
Medication needed at school? Yes or No

☐ **Sickle Cell Trait/ Disease** Yes or No
Does your child need Emergency Action Plan? Yes or No

☐ **Vision Problem:** Yes or No
_____Glasses _____Contacts

☐ **Hearing problem**
Hearing Aid: Yes or No

☐ **Learning Disorder:** _____

☐ Special Needs: _____

☐ Other conditions:_____
_____

Any Medications taken regularly at home? _____

Has your child been diagnosed by a physician as having a head injury/concussion within the past year?
____YES _____NO If yes, when?_____from what?_____

My child has: ___Health Insurance, ___Accident Insurance, ___Medicaid, and/or ___Dental Insurance

Parent/Guardian Signature: _____ Date: _____