Nurse Review Date/Initial: _____

STUDENT HEALTH INFORMATION

Information on this form to be filled out (updated) for each new school year.
Please return completed form to your school nurse as soon as possible.

Name: _____ Date of Birth: _____ Sex: □ Male □ Female

School: _____ Grade: _____ Date: _____

☐ **My child DOES NOT HAVE any health concerns/conditions. (If marked, go to Part "D")**

A. SPECIAL HEALTH CONCERNS

♦ **Please list medication/s:** _____

✱ □ **Diabetes**— Date of Diagnosis: _____ **My child has**: □ insulin pump □ insulin pen □ injected insulin

✱ □ **Seizure Disorder:** My child needs emergency medication for **Seizures.**

□ **Special Health Care Planning-** My child has special health care needs such as—wheelchair, tube feedings, breathing tube, catheter, intravenous tubes or other. Please describe your child's condition: _____

_____

B. LIFE THREATENING CONDITIONS

♦ **Please list medication/s:** _____

✱ **ASTHMA** □ ***Severe (If this box is checked, please answer the following questions):**

□ **Yes** □ **No** Does your child use a rescue inhaler routinely for asthma symptoms?
□ **Yes** □ **No** Has your child been hospitalized for asthma in the past year?
□ **Yes** □ **No** Has your child used steroids (prednisone) for asthma symptoms in the past year?

If "Yes" to above please list triggers: □ Food □ Animals □ Pollen □ Dust □ Exercise □ Other _____

If "No" to above or if your child has mild or moderate asthma, see box below "Health History—Non Life Threatening")

✱ **ALLERGY/ANAPHYLAXIS** □***Severe (child uses an Epinephrine prescription— example: Epipen, AUVI-Q)**

(*If your child has mild or moderate allergies, see box below **"Health History—Non Life Threatening"***

Please list Allergens (for example: fish, nuts) _____

Reaction with exposure: □ Difficulty breathing □ Rash □ Swelling of lips, tongue or mouth □ Itching □ Other _____

C. HEALTH CONDITIONS-NON LIFE THREATENING

♦ **Please list medication/s:** _____

Check any of the following conditions your child has had or may have:

□ **Asthma** (Mild / Moderate / Exercise Asthma - circle one)

□ **Allergies** (Mild / Moderate - circle one) *Allergens*: _____

□ **Hearing Concerns:** Hearing aids: **No / Yes**: ___R ___L

□ **Vision Concerns:** Glasses___ Contacts ___

□ ADD/ADHD □ Dental □ Serious Injury
□ Blood Disorder □ Depression/Anxiety □ Social/Emotional/
□ Bowel/Bladder □ Heart/Cardiac Concerns Behavioral
□ Cancer □ Orthopedic/Bone Concerns □ Other _____

♦ **Students requiring medications during the school day (prescription, over the counter, or herbal)** ***MUST*** have a written **Medication Authorization Form** (MAF) from their health care provider ***with*** signature of parent.

D. HEALTH HISTORY INFORMED CONSENT

This disclosure of student health information with the school is limited to the information necessary to serve the student's health or education interest. Your signature gives permission for the school nurse to share this information with school staff on a need-to-know basis for precautions, procedures, and emergency plans to protect your child at school. You further agree to bring to the attention of the school any ***major changes*** in the physical condition of your student.

Parent/Guardian Name (Printed): _____ Parent/Guardian Signature: _____

Primary Phone Number: _____ Alternate Phone Number: _____