American Overseas School of Rome

STUDENT NAME ________________________________, ________________________________
Date of Birth: ______________Grade _____ Primary Care Doctor ____________________________________

ALLERGIES

□ **Environmental** (*pollen, pets, dust*) □ **BEE STING** Epi-Pen needed? Yes__No___
□ **LATEX** Epi-Pen needed? Yes__No___ □ **FOOD**________________Epi-Pen needed ? Yes__No___
□ *Other allergy* ____
Comments:____

An Individual Action Plan and meds must be provided for any student with a life threatening allergy.*

□ ASTHMA

First diagnosed at age______yrs.
Triggers (ex. cold air, allergies, exercise, respiratory infection…)
____
Current medication:____
Comments:____

Student must provide medication / permission form if medication may be needed at school. The student may self-carry his inhaler ONLY after meeting with the School Nurse and providing written physician permission.*

□ DIABETES

First diagnosed at age______yrs.
□ **Oral medication name** _________________________ □ **Insulin type** ______________________ □ **Insulin Pump** □ **Glucose testing frequency** ___________________________
Comments____
____

Student must provide the Diabetes Medical Management Plan, physician order for testing and medications (Insulin, Glucagon, etc.) , glucometer / supplies, snacks, pump tubing, etc.*

□ SEIZURES

First diagnosed at age______yrs.
Current medication:____
Comments____
____

Student must provide medication / permission form providing written physician permission and Seizure Action Plan*

□ HEART DISEASE , Murmur, extra beats, High Blood Pressure

Diagnosis:____
Cardiologist name____________________________________
□ FAMILY SUDDEN DEATH of a heart attack before age 50? Relation/age______________________

Student must provide Physician documentation outlining restrictions or notation of NO restrictions annually

□ **ONE OF A PAIRED ORGAN** (ex. kidney, eye, testicle)

____

□ **Restrictions** ____

Comments____

Student must provide Physician documentation outlining restrictions or notation of NO restrictions

□ **BEHAVIORAL HEALTH** (ex. ADD, Depression, Anxiety, OCD, etc.)

First diagnosed at age______yrs.

Diagnosis: ________________________________

Treatment : ____

□ **CONCUSSION / HEAD INJURY**

Cause/age(s) ____

Comments____

□ **SURGERY**

Type/age ____

____

Additional relevant health information

____

____

EMERGENCY CONTACT INFORMATION (If parents are not reachable)

____

____

Date_________________

Parents/Guardians' Signature:

__________________________________ __________________________________

In the event that a parent cannot be reached, the school has my permission to take appropriate emergency medical action and have the student trasported to the nearest hospital.

Parents/Guardians' Signature:

__________________________________ __________________________________