SCHOOL HEALTHCARE OFFICE INFORMATION FORM

Year of Graduation 20____

ESKENAZI HEALTH

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

Nickname/prefers to be called: _____ **Sex:** _____ **Race:** _____

Student's home address: _____

Student's Cell #: _____-_____-_____ **Student's Email:** _____

Primary care physician_____ **Date of last visit**_____**Which hospital do you prefer?** _____

Is your child currently under treatment for a medical condition? Y or N If Yes, explain:

List all allergies to medications: _____

List all food allergies:_____

Is your child allergic to bee stings? Y or N **Does your child have seasonal allergies? Y or N**

Does your child have an EpiPen? Y or N **Do they carry their EpiPen on them at all times? Y or N**

If no EpiPen, what do you do when they have a reaction? _____

List all medications your child is taking, including natural remedies and 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 (month/year)	Reason
	_____ / _____	
	_____ / _____	

Does your child currently have or have they ever been treated for 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 an 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? ____mother ____father ____grandparent ____other:_____

Parent/Guardian 1: _____ Cell # _____-_____-_____ Work #: _____-_____-_____

Employer: _____ Email:_____ Parent Date of Birth: _____

Parent/Guardian 2: _____ Cell # _____-_____-_____ Work #: _____-_____-_____

Employer: _____ Email:_____ Parent Date of Birth:_____

Additional Emergency Contacts:

Name_____ Phone: _____-_____-_____ Relationship: _____

Name_____ Phone: _____-_____-_____ Relationship: _____

Your signature below will allow the school heathcare office or designated personnel to give, from their emergency supply, the following over-the-counter (OTC) medications on an as-needed basis. If your child asks for 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 consecutive days.

Please mark an "X" next to 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 child's health.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Print Name: _____