CISD Health History Information

Student Name _____ Birth Date ____ / ____ / ____ Grade _____

Please check whether your student has any of the following conditions and comment as necessary:

- ☐ Serious Allergy, specify: _____
  - Does your student need an Epi-Pen or antihistamine at school for the above allergy? ☐ Yes ☐ No
  - Does your student require a nut-free class and/or a nut-free table at lunch? ☐ Yes ☐ No
- ☐ Asthma _____
  - Does your student require an inhaler or nebulized medication at school? ☐ Yes ☐ No
- ☐ Diabetes _____
- ☐ Active seizures, specify type & date of last seizure _____
- ☐ Cardiac conditions _____
- ☐ Bleeding disorder _____
- ☐ Emotional concerns _____
- ☐ Bowel and/or bladder problems that require a classroom plan _____
- ☐ Hearing loss requiring hearing aides, amplification and/or preferential seating _____
- ☐ Vision problems requiring preferential seating _____
- ☐ Any other health/medical conditions requiring special procedures or treatments at school _____

  _____
- ☐ Medication that will be taken daily at school, please specify _____

  _____

All medication taken at school MUST be provided by the parent/guardian. Prescription medication taken daily at school must have current doctor's orders on file with the nurse. All medication must have a CISD Medication Adminitration (MAR) form on file. The nurse may administer non-prescription topical preparations when medically necessary.

Please contact your school nurse immediately if you have checked any of the above. Additional documentation and care plans are required to ensure a safe and healthy school environment for your student. Care plans and Medication Administration form (MAR) can be found under the Health Services tab of CISD home page.

My signature below gives the school nurse permission to share pertinent medical information with school personnel.

Parent/Guardian Signature _____ Date _____