PALMERTON SCHOOL DISTRICT
SCHOOL HEALTH SERVICES

SPECIAL HEALTH NEEDS

Student's Legal First, Middle, Last Name _____

Mother's Name _____
Father's Name _____

Whom Student Resides With _____

Address _____

DOB _____ Grade____ Gender____ Race_____ Phone Number _____
Previous School Attended _____

Name and phone number of Family Physician _____
Name and phone number of Family Dentist _____

Were there any problems or complications during pregnancy and/or delivery with mom and/or student? Yes No
If yes, explain _____

Did student have NICU stay? Yes No
If yes, explain _____

Premature? Yes No Gestation _____weeks Birth Weight_____

Infancy and Early Childhood (please check all that apply):

__Frequent Earaches
__Frequent Upset Stomach
__Frequent Sore Throat
__Frequency or Burning on Urination
__Constipation
__Diarrhea
__Vomiting
__Headaches
__Nosebleeds
__Seizures or Convulsions
__Unconsciousness
__Nightmares
__Speech Difficulties
__Stuttering
__Eye Problems
__Bed Wetting
__Hearing Defects
__Hyperactivity
__Short Attention Span
__Temper Tantrums
__Nail Biting
__Difficulty separating from parents
__Difficulty carrying our directions
__Unusual Fears
__Poor Coordination
__Frequent Stumbling or Falling

Comments: _____
_____

Was your child born with any birth defects? Yes No
If yes, explain _____

Has your child had any childhood diseases? Yes No
If yes, explain _____

Has your child ever had any serious illnesses, hospitalizations, fractures (broken bones) or operations? Yes No
If yes, explain _____

Does your child have any diagnoses or current health conditions? (Asthma, Diabetes, ADHD, ADD, Anxiety, Depression, Migraines, etc) Yes No
If yes, please list _____
If yes, are they currently under any treatment _____
Name of the treating provider_____
Please include any medications or accommodations required_____
_____
Is there an Asthma Action Plan in place? Yes No If yes, we will need a copy.

Has your child ever had any convulsions or seizures? Yes No
If yes, explain appearance _____
When was the last seizure? _____
Name of Neurologist, if applicable _____
Please include any medications or accommodations required _____
_____
Is there a Seizure Action Plan in place? Yes No If yes, we will need a copy.

Is your child receiving any therapies? (Speech, OT, PT, Counseling, etc) Yes No
If yes, please list _____

Does your child require any assistive devices? (Glasses, hearing aids, braces, etc) Yes No
If yes, please list _____

Does your child have any allergies? (Seasonal, food, insects, plants, medicines, etc) Yes No
If yes, please list _____
If yes, is there an Epi-Pen (Epinephrine) prescribed? Yes No
Name of the Allergist/treating provider _____
Is there an Action Plan in place? Yes No If yes, we will need a copy

Does your child need a special diet or have a food problem? Yes No
If yes, explain _____

Does your child have any activity restrictions? Yes No
If yes, please provide a note from his/her health care provider.

Please indicate if any relatives have or have had any of the following diseases:
M- Mother's family F- Father's family
__Allergies __Asthma __Diabetes __Heart Disease __Lung Disease
__Psychological problems __Convulsive (seizure) disorders __Emotional problems

Does your child take any medication on a regular basis? Yes No
If yes, please include the name, dosage, timetable, and reason for taking the medication.
_____
_____
_____
_____
_____

****If there are any changes to your child's health or any new diagnoses throughout their school years, please notify your child's nurse immediately.**

If your child needs to take any medication during the school day, we MUST have an order from a healthcare provider. The medication MUST be brought to the health office by an adult, and it MUST be in the original container. The label on the container must include the name of the child, the name of the medication, the dosage, and the timetable for dispensing the medication. If the medication is prescribed, a signed authorization from the healthcare provider must accompany the medication. Over the counter medications only need a written authorization from the parent or guardian.

Signature _____ Date _____

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