Acalanes Union High School District

HEALTH INFORMATION FORM

Please fill out this form upon your student's enrollment in the district OR if there are changes in his/her health status. In order to provide the best learning experience for the student, it is important that we have an understanding of the student's health status. This form will be provided to the School Nurse. Please contact your School Nurse to discuss any health problem in more detail.

THE STUDENT MUST HAVE CURRENT IMMUNIZATION DATES ON FILE WITH THE SCHOOL NURSE.
BE SURE IMMUNIZATION INFORMATION IS SUBMITTED TOGETHER WITH THIS FORM OR IS CURRENTLY ON FILE

Date: _____ Student's Name: _____ _____ _____
(Last) (First) (Middle)
School: _____ Grade: _____ Date of Birth _____ Class of: _____

Please check the appropriate boxes:
**Required Medical forms/Careplans on website/QR code on page 2, school sites, and from School Nurses. ALL forms require DOCTOR and Parent Signatures.*

- ☐ **Allergies***: (list type/medication* on next page)
  - ☐ Allergy, **LIFE THREATENING** List:_____
    Emergency/School Medications* ☐ YES ☐ NO
  - ☐ Allergy, Non-Life threatening, List: _____
- ☐ **Arthritis** _____
- ☐ **Behavior/Developmental Disorders** (describe on next page)
  - ☐ ADD ☐ ADHD (List medication* on next page)
  - ☐ Autistic Spectrum Disorder
- ☐ **Blood/Blood products NOT TO BE GIVEN**
- ☐ **Cancer** _____
- ☐ **Cardiovascular** (Describe on next page)
  - ☐ Hypertension
  - ☐ Heart Condition (describe)
  - ☐ POTS
  - ☐ Fainting /Vasovagal episode
- ☐ **Concussion/head injury** (give date/describe on next page)
- ☐ **Ears/Nose/ Throat** (describe on next page)
  - ☐ Nose bleeds – frequent/ severe
  - ☐ Vocal cord disorder
  - ☐ Hearing loss ☐ Right ☐ Left
  - ☐ Hearing aids ☐ Right ☐ Left
- ☐ **Endocrine Disorder** (describe on next page)
  - ☐ Diabetes* Type 1 (careplan*/CONTACT SCHOOL NURSE)
  - ☐ Diabetes * Type 2
  - ☐ Thyroid Condition _____
  - ☐ Other: _____
- ☐ **Gastrointestinal Disorder** (describe on next page)
  - ☐ Celiac Disease
  - ☐ Irritable Bowel Syndrome
  - ☐ Crohn's Disease
  - ☐ Ulcerative Colitis
  - ☐ Gastrostomy Feeding Tube
- ☐ **Genetic condition** (describe on next page)
  - ☐ Blood Disorder/Hemophilia (list type/medication on next page)
  - ☐ Other: _____
- ☐ **Gynecological Issue** (describe on next page)
  - ☐ Menstrual cramps /Severe
- ☐ **Immune System Disorder** (describe on next page)
- ☐ **Kidney/Urinary Disorder** (describe on next page)
- ☐ **Liver Condition** (describe on next page)
- ☐ **Lyme disease** (describe on next page)
- ☐ **Musculoskeletal Condition** (describe on next page)
  - ☐ Scoliosis (describe on next page
  - ☐ Orthopedic/Joint Disorders
- ☐ **Neuromuscular condition** (describe on next page)
  - ☐ Cerebral Palsy
  - ☐ Muscular Dystrophy
- ☐ **Neurologic Condition** (describe on next page)
  - ☐ Headaches – Severe/Migraine (list meds on next page)
  - ☐ Seizure Disorder*/Epilepsy (careplan*/describe on next page)
    Emergency/School Medications* ☐ YES ☐ NO
  - ☐ Tourette's syndrome
  - ☐ VP Shunt
- ☐ **Organ Transplant**
- ☐ **Psychological Disorder/Mental Health** (list treatment on next page)
  - ☐ Anxiety
  - ☐ Depression
  - ☐ Disorder Eating
  - ☐ Sleep disorder
  - ☐ Other _____
- ☐ **Respiratory**
  - ☐ Asthma ☐Mild ☐Moderate to Severe ☐Carries Inhaler
    (careplan*/medication info on next page)
  - ☐ Cystic Fibrosis
  - ☐ Tracheostomy
- ☐ **Skin Problem**_____
- ☐ **Speech** disorder/issue
- ☐ **Surgery** history (give date/explain on next page)
- ☐ **Vision Impairment**
  - ☐ Prescription glasses/contact lenses
  - ☐ Color vision defect
- ☐ **OTHER**: _____

☐ **NO KNOWN HEALTH PROBLEMS**

The School Nurse shares health information with student's teachers on an as-needed basis. ☐AGREE ☐ DECLINE sign here: _____

PARENT AUTHORIZATION FOR EXHANGE OF INFORMATION WITH STUDENT'S PHYSICIAN

I hereby give my consent to the School Nurse to receive from or send any information concerning my child _____
Doctor: _____Phone: _____ Email: _____
Parent Printed Name _____ OR **DECLINE** consent, sign here: _____
Required: Signature of Parent/Guardian who filled out this form: _____ Date: _____

Date: _____ Student's Name: _____

Please reference and explain any medical/health conditions and list medications here:

Please download and print any of the following forms/care plans for these significant health conditions and take to your physician to fill out and sign.
NOTE: BOTH parent and physician signatures required. Email or return the hardcopy to the School Nurse:

https://drive.google.com/drive/folders/1dwEYXj5NDc3Dbjw_sgxoy_JMZVRXkeaM

