Campus: _____ School Year: _____

Academy ISD Health Services Student Health Form

Student	DOB	Grade	☐ MALE ☐ FEMALE

COMPLETE ALL BOXES THAT APPLY TO YOUR CHILD

The parent or guardian is responsible for providing the school with any medication, special diet, or equipment that the student will require during the school day. Check the school website or clinic to obtain correct medication, procedural, and emergency forms. The parent or guardian is responsible for providing the School Nurse with any necessary medical information, appropriate authorization forms, and written consent to exchange information with the student's physician. The information below will be secured in the health services clinic and the district's electronic systems. This information will be shared only on a "need to know" basis.

Please provide doctor's orders & plans for seizures, asthma, allergies, diabetes, heart issues, and any other chronic health conditions or those requiring daily management.

You may use the comment section to describe reactions, treatments, signs, symptoms, severity, medications, what should be done at school, special instructions, etc.

My child has medical, vision and/or hearing conditions that may affect his/her school day: ☐ No ☐ Yes If YES, please complete below.	**THIS COLUMN:** FOR NURSE USE ONLY
☐ Vision Conditions ☐ Contacts ☐ Glasses ☐ Other:_____ ☐ Hearing Conditions ☐ Hearing aid(s) ☐ Other: _____	☐ Data Entered
☐ **ADD/ADHD/**Other **Behavioral Issue** (be specific): _____ Medication: ☐ At home_____ ☐ At school _____ Comments:	☐ Data Entered ☐ Standard Med Procedure ☐ No Ongoing Nursing Mgmt. Currently
☐ **Asthma*** ☐ Triggers ☐ Exercise ☐ Environmental ☐ Other: _____ ☐ Mild ☐ Moderate* ☐ Severe* Physical Education Restrictions: ☐ None ☐ Self limits ☐ Other: _____ Will student self-administer inhaler medication? ☐ Yes* ☐ No ☐ In School* ☐ At Home Medications: ☐ Inhaler ☐ Oral ☐ Nebulizer List: _____ Comments:	☐ Data Entered ☐ Standard Med Procedure ☐ Emergency Care Plan ☐ RN_____ ☐ No Ongoing Nursing Mgmt. Currently
☐ **Food Allergy***: _____ ☐ Mild ☐ Moderate* ☐ Severe* ☐ Anaphylaxis* ☐ Coughing ☐ Hives ☐ Difficulty Breathing ☐ Wheezing ☐ Allover Swelling ☐ Other Describe Reaction: Medications: ☐ Oral Antihistamine (Benadryl, etc.) ☐ Epi-Pen ☐ In School* ☐ At Home Comments:	☐ Data Entered ☐ Standard Med Procedure ☐ Emergency Care Plan ☐ RN_____ ☐ No Ongoing Nursing Mgmt. Currently
☐ **Medication Allergy**: _____ ☐ Mild ☐ Mod ☐ Severe ☐ Anaphylaxis Describe Reaction:	☐ Data Entered ☐ No Ongoing Nursing Mgmt. Currently
☐ **Insect/Other Allergy**: _____ ☐ Mild ☐ Moderate* ☐ Severe* ☐ Anaphylaxis* ☐ Coughing ☐ Hives ☐ Difficulty Breathing ☐ Wheezing ☐ Allover Swelling ☐ Other Describe Reaction: Medications: ☐ Oral Antihistamine (Benadryl, etc.) ☐ Epi-Pen ☐ In School* ☐ At Home Comments:	☐ Data Entered ☐ Standard Med Procedure ☐ Emergency Care Plan ☐ RN_____ ☐ No Ongoing Nursing Mgmt. Currently
☐ **Diabetes** Type 1* ☐ **Diabetes** Type 2* Currently prescribed treatments to be used: ☐ In School ☐ At Home Medications: ☐ Injectable_____ ☐ Oral_____ Comments:	☐ Data Entered ☐ Standard Med Procedure ☐ Emergency Care Plan ☐ RN_____ ☐ No Ongoing Nursing Mgmt. Currently
☐ **Seizures*** (Type of Seizure): ☐ Absence (staring/unresponsive) ☐ Complex partial ☐ Generalized tonic-clonic (grand mal, conclusive) ☐ Other (explain)_____ Date of Last Seizure: _____ Length of Seizure: _____ Currently meds to treat seizures: _____ ☐ In School* ☐ At Home Comments:	☐ Data Entered ☐ Standard Med Procedure ☐ Emergency Care Plan ☐ RN_____ ☐ No Ongoing Nursing Mgmt. Currently

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☐ **Heart Condition*** (be specific): _____ PE Restrictions: ☐ Yes ☐ No _____ Comments:	☐ Data Entered ☐ Standard Med Procedure ☐ Emergency Care Plan ☐ RN_____ ☐ No Ongoing Nursing Mgmt. Currently
☐ **Kidney/bladder** disorder (be specific)	☐ Data Entered ☐ Standard Med Procedure ☐ Emergency Care Plan ☐ RN_____ ☐ No Ongoing Nursing Mgmt. Currently
☐ **Cancer** (be specific) ☐ **Blood Disorder** (be specific)	
☐ **Surgery** (be specific)	
☐ Other (be specific)	
☐ **Special procedures** (e.g. catheterization, cardiac monitor, etc.) Required IN SCHOOL ☐ Yes ☐ No	
My child plans to ride the bus ☐ Yes ☐ No Bus Number: _____	☐ Transportation Plan ☐ Notified

*** Asthma, seizures, severe allergies, diabetes, cardiac issues, or other chronic illnesses**: please provide doctor's orders, emergency plans, and medications as needed with proper forms filled out from the school's website to nurse office. ***Seizures**: students with seizures are to have a seizure management and treatment plan signed by parent and physician upon enrollment or the beginning of the school year [Texas Education Code (TEC) 38.032]. *** Medication administration at school**: prescription medication to be given at school must be in the original bottle with the student's name and instructions for administration on the label. A permission form [Medication Administration Form] must be signed by the parent/guardian for each medication. Please read the school's website for further instructions and forms. [TEC 22.052]. ***Self-carry of medication at school**: students who will self-carry/self-administer asthma or anaphylaxis medications MUST turn in a written authorization from physician AND authorization signed by parent to receive while at school/attending school events [TEC 38.015 & 22.052].

The following first aid supplies are approved by a physician for use on Academy ISD students: isopropyl alcohol-antiseptic; aloe vera gel-sunburn; Neosporin- topical antibiotic ointment; calamine lotion – itching and rashes; Carmex – lip balm; hydrocortisone- topical steroid cream; hydrogen peroxide- to clean abrasions, cuts; ice packs- anti-inflammatory, pain management; sterile saline solution- rewetting solution for contacts; meat tenderizer- insect bites; sting relief- antiseptic and pain reliever for insect bites; salt- sore throat; Tinactin- topical antifungal; Vaseline- chapped lips, skin; Aveeno lotion- dry skin; Jergens- dry skin; purified water ophthalmic solution- eye wash; and saline wound flush-cleaning wounds. Please indicate if any of these products should not be used: _____.

By signing below, you agree to allow these products to be used on your student by Academy ISD staff, unless otherwise indicated above.

By signing below, the parent/guardian takes responsibility for providing doctor's orders, emergency plans, medications, and supporting documents needed to care for your child's disclosed conditions while in school. If the school nurse deems it necessary, I grant permission to notify my child's teacher(s) of his/her health condition(s).

List phone numbers of those who should be called first when your child is sick or injured. In case of serious accident or illness and no one designated in my emergency contacts can be reached, I authorize the school to arrange for all necessary medical services for said child on my behalf, and I will be responsible for all necessary medical services for said child on behalf, and I will be responsible for all medical costs incurred.

1. Parent/Guardian:	Relationship to Student:	Phone:
Email:	Other phone:	Work phone:
2. Parent/Guardian:	Relationship to Student:	Phone:
Email:	Other phone:	Work phone:
3. Emergency contact & relationship to student:	Phone:	Other phone:
4. Emergency contact & relationship to student:	Phone:	Other Phone:
Physician Name	Facility:	Phone:
Hospital of Choice	Insurance: ☐ Private ☐ CHIP ☐ Medicaid ☐ None	
Parent Signature:	Date:	
Campus Nurse: (print & sign)	☐ RN ☐ LVN	Initial / Date:

Date Filed in Nurse Office: