

Complete this form if your student has new or updated health concerns the school should be aware of

Student Name: _____ Birthdate: _____ Grade: _____
 School: _____ School Year: _____ Insurance: ☐ YES ☐ NO
 Health Care Provider Name: _____ Phone: _____

☐ **NO KNOWN CONDITION** ☐ **INTERPRETER NEEDED** Language: _____

Life Threatening Health Conditions ☐ YES ☐ NO

- ☐ Anaphylaxis (Epinephrine prescribed)
☐ Allergen/s: _____
☐ Diabetes: ☐ Type 1 ☐ Type 2
☐ Seizures – (Emergency medication required)
☐ Asthma – Severe
☐ Other Life-Threatening Condition: _____

**State law requires that students with life-threatening conditions have a care plan completed and have medications in place.*

Respiratory/Breathing

- ☐ Asthma - Current
☐ Asthma - Ever diagnosed
☐ Asthma - Exercise Induced
☐ Reactive Airway Disease
☐ Other Respiratory Conditions _____

Eyes / Ears

- ☐ Hearing Impairment
☐ Frequent Ear Infections
☐ Wears glasses or contacts
☐ Other: _____

Allergy, Nutritional

- ☐ Allergy - Food: _____
☐ Allergy - Insect _____
☐ Allergy - Mold, dust, pollen. Describe: _____
☐ Allergy - Medication: _____
☐ Allergy - Other _____

Gastrointestinal (Digestive)

- ☐ Celiac Disorder
☐ Food Intolerance (including religious preference): _____
☐ Chronic Constipation ☐ Encopresis
☐ Gastric Reflux ☐ Heartburn ☐ GERD
☐ Feeding concerns: _____
☐ Other Digestive Issues: _____

Mental or Behavioral Health

- ☐ Anxiety
☐ Depression
☐ Sleep Disorder
☐ Other Mental or Behavioral Health
☐ Condition: _____
☐ Currently receiving therapy. Frequency: _____

Nervous System (Brain)

- ☐ ADHD/ADD diagnosed date: _____
☐ Autism Spectrum ☐ Headaches, Recurring
☐ Seizures, Type: _____
☐ Traumatic Brain Injury/Concussion.
 Date of Injury: _____
☐ Other Neurological Condition: _____

Bleeding

- ☐ Frequent nosebleeds
☐ Other Blood Condition: _____

Bones / Physical Activity

- ☐ Condition: _____
☐ Wheelchair, Crutches, Braces: _____
☐ Any recent broken bones or other injuries affecting
☐ Mobility _____

Cardiac / Heart / Blood Flow

Please Describe: _____

Medications My student requires medication at school for the current school year: ☐ YES ☐ NO Meds at Home: ☐ YES ☐ NO
 Medication: _____

Recent Hospitalizations or Surgeries. Please describe: _____

Other Health Concerns or information not listed: _____

The information provided is kept in strict confidence and will only be shared with appropriate school staff who need to know in order to provide for the health and safety of the student. It is the responsibility of the parent/guardian to notify the school nurse should health concerns arise or conditions change, and to provide correspondence as needed from the child's healthcare provider regarding their condition(s).

Signature: _____ Printed Name: _____ Date: _____