Request for Health Information

Date: _____

Must be completed annually

Please return the following form to your child's teacher **as soon as possible.** This information will be reviewed by the School Nurse.

School:	Grade:	Homeroom Teacher:	
STUDENT NAME:	**Date of Birth:**		Bus #:
Parent/Guardian:		Daytime Phone (1):	
Parent/Guardian email:		Daytime Phone (2):	
Emergency Contact:		Phone:	
Current Doctor/Practice:		Phone:	
Current Medications:			
Medications needed at school?: ☐ No ☐ Yes* (list): _____ ***(*) Medication consent form is required to be signed by the health care provider and the parent/guardian. Medication cannot be given until consents have been received. Consent form will be provided upon request.***			

Check the condition(s) your child has below, OR

☐ MY CHILD HAS NO KNOWN HEALTH CONDITIONS

(You may stop here if there are no known medical conditions. Please sign at the bottom and return form).

__ **ADD/ADHD** (See Below)	__ Cerebral Palsy	__ Hearing Aid/Loss	__ Neuromuscular Disease
__ **Allergies, Severe** (See Below)	__ Crohn's Disease/IBS	__ **Concussion** **Date Diagnosed:** _____	__ Nosebleeds, frequent and/or severe
__ **Asthma** (See Below)	__ Cystic Fibrosis	__ Heart Conditions Type: _____	__ Orthopedic Impairment
__ Autism	__ **Diabetes** (See Below)	__ Hemophilia/Bleeding Disorder	__ Renal/Kidney Disease
__ Cancer/Leukemia Date Diagnosed: _____	__ Down Syndrome	__ **Mental Health Diagnosis** (See Below)	__ Juvenile Rheumatoid Arthritis
	__ **Epilepsy/Seizures** (See Below)	__ Migraine Headaches	__ Sickle Cell Anemia
	__ Glasses/Contacts		__ Ulcers/Gastric Reflux
			__ Other: _____

FOR THE FOLLOWING CONDITIONS, PLEASE PROVIDE ADDITIONAL INFORMATION:

Severe Allergies Notify your School Nurse ***IMMEDIATELY*** If anaphylaxis may occur.	What is your child allergic to? ☐ Peanuts ☐ Tree Nuts ☐ Milk ☐ Eggs ☐ Insect Stings ☐Other: _____ Is medication needed at school for allergies? ☐ No ☐ Yes* If yes, name: _____ Desired Location of Medication: ☐ Carried by student* **(requires self-carry form)** ☐ Health Room Date/Type Last Reaction: _____ Check the type of allergic reaction that occurs: ☐ Hives ☐ Swelling ☐ Difficulty Breathing ☐ Other: _____
Asthma	Is medication needed at school for asthma? ☐ No ☐ Yes* If yes, name: _____ Desired Location of Medication: ☐ Carried by student* **(requires self-carry form)** ☐ Health Room Date of last episode: _____ Check what is likely to cause an asthma flare: Triggers: ☐ Environmental ☐ Seasonal ☐ Exercise induced ☐ Upper respiratory infection ☐ Other:_____
Epilepsy/ Seizures	Type: ☐ Convulsive ☐ Non-Convulsive Date of last seizure: _____ Is emergency medication needed at school? ☐ No ☐ Yes* If yes, name: _____
Diabetes	Type I ☐ Type II ☐ Diagnosis Date: _____ * **Insulin** by: ☐ Pump ☐ Injections **CGM** (i.e.: Dexcom): ☐ No ☐ Yes, Type: _____ ***Please call to schedule Nurse Conference - Notify your school nurse immediately if newly diagnosed***
ADD/ADHD Mental Health	Type: ☐ ADD ☐ ADHD ☐ Anxiety ☐ Depression ☐ Other: _____ Medication(s) used for treatment: _____

Please be aware that the information you provide will be shared with staff on a need-to-know basis.

In the event of an emergency, and you cannot be reached, I give permission for the School Nurse to contact my doctor for further instructions on medications or care.

_____ _____

Signature of Parent/Guardian **Date**