

## 2017 - 2018 Student Health Form

**Student's Legal Name** \_\_\_\_\_ Birthdate: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Gender: \_\_\_\_\_ Grade: \_\_\_\_\_

**HEALTH CONCERNS:** Please **X** and explain if your child has any of the following

*\* Submit action plan for starred conditions.*

- No health concerns**
- Allergies\*** to \_\_\_\_\_; reaction \_\_\_\_\_
- Food Intolerance to \_\_\_\_\_; reaction \_\_\_\_\_
- Asthma\***: \_\_\_\_\_
- Diabetes\***: Type 1 Type 2 Managed by (circle): Diet/Activity Oral meds Insulin injections Pump
- Seizures\***: type/description/frequency \_\_\_\_\_
- Heart Condition \_\_\_\_\_
- Concussion / Traumatic Brain Injury - date \_\_\_\_\_
- Social/emotional/behavioral/mental health concerns \_\_\_\_\_
- Recent surgeries, hospitalizations, injuries \_\_\_\_\_
- Activity Restrictions \_\_\_\_\_
- Implanted Devices \_\_\_\_\_
- Special Education / 504 Plan (circle)
- Bowel / Bladder Concerns \_\_\_\_\_
- Other Health Concern \_\_\_\_\_

My child has health insurance \_\_\_\_\_ (  I request assistance to obtain this)

Preferred Hospital in the event of an emergency \_\_\_\_\_

**MEDICATIONS:** List **ALL** medications that this student takes

*\* **WRITTEN CONSENT IS REQUIRED BY BOTH THE STUDENT'S GUARDIAN AS WELL AS THEIR HEALTH CARE PROVIDER.** Complete a Medication Administration Form for **ANY** medication (BOTH PRESCRIPTION AND NON-PRESCRIPTION) needing to be administered **during school hours** (forms are available in the Health Office).*

<u>Medication Name</u>	<u>Dose</u>	<u>Purpose</u>	<u>How Often</u>	<u>Given during school?</u>

*I attest to the information provided. I acknowledge that it is my responsibility to inform the school of any changes to the health status of this student including health conditions, needs, medications, and/or allergies. I understand and agree that this student may receive a routine screening for any vision and hearing deficiencies. I will comply with all school illness and medication policies. Furthermore, I give permission for school health staff to confidentially exchange health information - both within the school as well as with outside health care providers - for use in meeting this student's health and educational needs in school.*

\_\_\_\_\_  
**Parent/Guardian Printed Name (s)**                      **Phone Number (s)**                      **Parent/Guardian Signature (s)**                      **Date**