

STUDENT HEALTH CONCERNS

STUDENT NAME _____ GRADE _____ BIRTHDATE _____

➤ DOES YOUR CHILD HAVE A LIFE THREATENING HEALTH CONDITION? Yes ___ No ___

➤ DOES YOUR CHILD CURRENTLY HAVE HEALTH INSURANCE? YES ___ NO ___

Allergies:

Bee Sting Allergy (A10/comment)
_____ Severe and needs medication at school
and medical follow-up for a bee sting
Food Allergy (A15/comment)
_____ Severe reaction to: _____
_____, and needs
needs medication at school and
medical follow-up
_____ Mild reaction and needs to avoid:

Asthma: (B10/comment)

_____ Needs medication at school
_____ Does not need medication at school.

Attention Deficit Disorder: (R20/comment)

_____ Needs medication at school and home
_____ Medication at home only
_____ Diagnosed, but not medicated.

Physical restrictions that would limit activity: (P/comment) (Requires Health Care Provider orders)

_____ Must avoid this activity: _____
_____ Restricted because of: _____
_____ Accommodations needed: _____

Diabetes: (D)

_____ Insulin Dependent (Type 1) and will need
a school program set-up (D10)
_____ Non-insulin (Type 2) dependent (D12)
Medication _____
_____ Other blood sugar problems(comment)

*All health concerns will be brought to the attention of the school nurse and may be shared with school personnel on a "need to know basis."

* If medication is needed at school, you must submit medication forms that are completed by the Health Care Provider before medication can be given.

Hearing concerns: (H)

_____ History of ear infections; most recent
infection _____ (H 30)
_____ Wears hearing aid in ___right ___left
ear(H20)
_____ Needs classroom accommodation
(comment)

Seizures: (F/comment)

Type: _____
_____ Needs medication at school
_____ Takes medication at home
_____ History of seizures, but not presently
medicated (Type: _____)

Vision Problems: (E/comment)

_____ Blind in one eye: ___Right ___Left
_____ Wears glasses or contacts (E11)
_____ Other eye conditions: _____

Heart Problems: (C/comment)

_____ Please list: _____

Behavioral concerns-Significant (R40/comment)

_____ Behavior plan in place
_____ Receiving counseling services (R41)
_____ Previous behavior program placement
_____ Needs medication at school
_____ Takes medication at home only
_____ Other information: _____

Other: (050/comment)

_____ Health concerns that would affect school
performance: _____
_____ Medication your child needs at school not
listed above: _____
_____ Accommodations your child may need for a
disability _____

Doctor _____ Phone _____

Dentist _____ Phone _____

AUTHORIZATION FOR EMERGENCY PROCEDURE

If I (parent/guardian) and/or authorized physician named above cannot be reached at the time of an emergency, and the immediate observation or treatment is urgent in the judgment of the school authorities, I authorize and direct the school authorities to send the student (properly accompanied) to the hospital or doctor most easily accessible. I understand that I will assume full responsibility for the payment of any services rendered.

If I cannot be reached or am unavailable to pick up my child for an illness, injury, or a disaster situation, I give permission to release my child to the emergency contacts listed on my child's registration information record.

Parent/Guardian Signature: _____ Date: _____