2017 – 2018 STUDENT HEALTH INVENTORY

Your child's learning depends upon good health. To assist in providing health services at school, please complete the following and return to the School Nurse, **by September 1st, 2017.**

Name _____ Boy ____ Girl ____ Date of Birth _____
Last First Middle

Grade _____ Teacher _____

Does the student have insurance? Yes _____ (private_____ or Medicaid_____) None _____

Parent/Guardian _____ Home Phone # _____

Cell # _____

Parent's Employment _____ _____

Father Work phone # _____ Mother Work phone # _____

Emergency Contacts _____ _____
(Other than parent) Name Relationship Name Relationship
Phone # _____ Phone # _____

Doctor's name _____ Date of last physical exam_____

Dentist's name _____ Date of last dental exam_____

Is your child under an orthodontist's care? Yes __ _____ No _____ Doctor's name _____

Has your child had the chicken pox? No_____ Yes _____ If yes, when (month and year) _____

DOES YOUR CHILD HAVE:

Allergies No _____ Yes _____ To drugs, **Food**, insects, pollen? Please list_____

_____

Has the allergy required emergency action in the past?
No _____ Yes _____ Comments _____

Bee Sting Allergy No _____ Yes _____ Describe reaction: _____

Difficulty breathing? _____ Need emergency medication? _____

ADHD/ADD No _____ Yes _____ Medications? Please list below:_____

_____

Asthma No _____ Yes _____ Triggered by: _____ Treatments: _____

Name of Doctor that diagnosed _____ Date_____

Diabetes No _____ Yes _____ Takes insulin? No _____ Yes _____ Date diagnosed:_____

Emotional/Mental Health No _____ Yes _____ If yes, Diagnosis:_____Medications? _____

Please list:_____

Epilepsy/Seizures No _____ Yes _____ Describe seizure: _____
Date of last seizure: _____ Medication:_____
Is student currently under a doctor's care for seizures? No ___ ____Yes _____
Doctor's name_____

Heart condition No _____ Yes _____ Describe:_____
Any medications or physical restrictions due to heart condition:_____

Bone/joint problem No_____ Yes _____Describe:_____
Any physical restrictions?_____

Takes daily medications? No _____ Yes _____ At school? No_____ Yes _____ Emergency only? No _____ Yes_____

Name of medication _____Dosage _____Times taken _____
Reason for taking _____

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Reason for taking _____

Name of medication _____Dosage _____Times taken _____
Reason for taking _____

Eyes: glasses _____ (reading ____ distance ____) contacts ____ crossed ____ lazy eye ____ wear at all times _____
Ears: frequent infections _____ tubes _____ hearing difficulty _____ (explain) _____
Hearing aid – right _____ left _____ Wear at school? Yes _____ No _____ Other _____

Other Concerns (please checkmark):

Blood Disorder _____, explain_____
Neurologic _____, explain _____
Skin problems _____, explain_____
Headaches _____, explain _____
Blood pressure problems _____, explain _____
List: Childhood diseases, serious illness, and injuries _____
Surgeries_____
Condition that prevents PE participation _____

SPECIAL EDUCATION OR SERVICES student receives: LD _____ Speech/Language ___ OT/PT _____

Counselor _____ Special diet _____

Requires Special Health Care (explain) _____

HEALTH INFORMATION OR CONCERNS: _____

_____

SPECIAL PROCEDURES REQUIRED: _____

_____

CONSENT FOR BASIC SERVICES

The Nursing Office provides a basic school health services program for students, preschool through 12th grade. This service is not to replace the care your child receives from your regular doctor or clinic, but will provide:

1. Basic Emergency and First Aid Care
2. Administration of medication for your child with a doctor's order and your request
3. Age appropriate screening exams for vision, hearing, dental screening with varnish treatment, height, weight, blood pressure and spinal problems
4. Assistance to help correct any needs discovered
5. Health information for you and your child
6. Health care plans for special needs, developed with students and parents

The school must collect health information on all students, which includes immunization records, history of health and development, medications, emergency instructions and directions for special health needs.

Participation in our school health services program is voluntary and you may withdraw your permission at any time. I give permission

for _____ to participate in the health program.
(Student's name)

I understand the purpose of the program, and agree for my child to receive the above services with the exception of

#_____.

_____ _____

Parent/Guardian signature **Date**

The following medications are available in the Nursing Office, please indicate if you want your child to receive these medications:

Tums Yes_____ No_____, Cough Drops Yes _____ No _____,

Throat Spray Yes_____ No_____, Tylenol Yes _____ No_____, Ibuprofen Yes_____ No_____