



Student Health Information Form

20____ - 20____

Student Name: _____ Birth Date: _____ School: _____ Grade: _____

Will your student be riding a bus this school year? Yes _____ No _____

Does your child wear glasses/contacts or require any form of hearing supports? (Please circle which) Yes _____ No _____

Would you like know *EVERY* time your child comes to the health office this year? Yes _____ No _____ Only as needed _____

Does your student have any non-life threatening allergies? Yes _____ No _____

If yes, please list the allergies, reactions, and how you treat at home:

Please list current medications your child is taking routinely at home (prescribed, over the counter, and supplements):

Will daily medication need to be given at school? *Yes _____ No _____

If yes, list medication(s): _____

****Permission to Give Prescription/Homeopathic Medications at School* form is required to be signed by the health care provider and the parent/guardian. Medication cannot be given until consents have been received***

CHECK THE CONCERN(S) YOUR CHILD HAS BELOW, OR (initial) _____ MY CHILD HAS NO KNOWN HEALTH CONDITIONS

(You may stop here if there are no known medical conditions. Please sign on page 2 and return form).

☐ Accidents/Injuries ☐ ADD/ADHD (See below) ☐ Allergies, Severe (See below) ☐ Allergies, seasonal ☐ Asthma (See below) ☐ Autism ☐ Behavior Concerns ☐ Cancer/Leukemia Date Diagnosed: _____ Treatment Status: _____ ☐ Developmental Delays	☐ Cerebral Palsy ☐ Crohn's Disease/IBS ☐ Cystic Fibrosis ☐ Diabetes (See below) ☐ Down Syndrome ☐ Epilepsy/Seizures (See below) ☐ Gastric Reflux/Ulcers ☐ Genetic Disorder ☐ G-Tube or other type of feeding tube (requires tube feed authorization form)	☐ Head Injury/Concussion Date Diagnosed: _____ Fully recovered?: _____ ☐ Heart Conditions Type: _____ ☐ Hemophilia/Bleeding Disorder ☐ Immune Conditions ☐ Mental Health Diagnosis (See below) ☐ Migraines/Headaches (See below)	☐ Mobility Impairments ☐ Neuromuscular Disease ☐ Orthopedic Disability ☐ Daily Oxygen use (requires provider order) ☐ Renal/Kidney/Bladder ☐ Skin Conditions ☐ Stomach/Intestines ☐ Tracheostomy ☐ Vision/Hearing Problem ☐ Other: _____
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If yes to any of the above, please provide additional details:

FOR THE FOLLOWING CONDITIONS, PLEASE PROVIDE ADDITIONAL INFORMATION (Additional conditions on back)

Severe Allergies Notify Nurse <u>immediately</u> if anaphylaxis may occur.	What is your child allergic to? _____ Is medication needed at school for allergies? Yes _____ No _____ If yes, name: _____ Location of Medication: Carried by student (requires self-carry form) _____ or Health Office (requires anaphylaxis action plan) _____ Type of reaction (difficulty breathing, hives etc): _____
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	Date of last reaction: _____
Asthma	Is medication needed at school for asthma? Yes _____ No _____ If yes, name: _____ Location of Medication: _____ Carried by student (requires self-carry form) _____ or Health Office (requires CO asthma action plan) _____ Date of last episode: _____ Triggers (exercise etc.): _____
Epilepsy/Seizures	Type: _____ Date of last seizure: _____ Is emergency medication needed at school? *Yes _____ No _____ If yes, name: _____ *Requires Seizure Action Plan*
Diabetes	Type I _____ Type II _____ Date of diagnosis: _____ Insulin by: Pump (list type) _____ Injections _____ Pen _____ CGM: Yes (list type) _____ No _____ Type of rescue medication (Baqsimi, glucagon etc.): _____ Is your student independently managing? Yes (requires Self-Management Plan) _____ No _____ Please call to schedule conference with District Nurse – notify immediately if newly diagnosed.
ADD/ADHD Mental Health	ADD _____ ADHD _____ Anxiety _____ Depression _____ Other: _____ Is medication needed at school? *Yes _____ No _____ If yes, name: _____ *Requires Permission to Give Meds at School Form*
Migraine/ Headaches (Please specify which)	How often does your child experience migraines: _____ Triggers/aura: _____ Is medication needed at school? *Yes _____ No _____ If yes, name: _____ *Requires provider orders or headache/migraine action plan*

Is there anything else you would like for us to know to better care for your child?

Parent/Guardian Signature _____ Contact Phone # _____ Date _____
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The following forms can be found on the Elizabeth School District Health page:

1. Permission to Give Prescription/Homeopathic Medications at School
2. Allergy and Anaphylaxis Action Plan &
 - a. Self-Carry Agreement (Middle and High School Students only)
3. Asthma Action Plan &
 - a. Self-Carry Agreement (Middle and High School Students only)
4. Tube Feeding Authorization Form
5. Seizure Action Plan
6. Permission for Nursing Procedure

Please contact the District Nurse if you would like to discuss any of the above information (303-646-6730)



**ELIZABETH SCHOOL DISTRICT
NON-PRESCRIPTION MEDICATIONS
PERMISSION FORM: 20_____ - 20_____**

New forms must be completed every year

Student Name: _____ DOB: _____ School: _____

Over-the-counter (OTC) medications are drugs that do not require a prescription and are purchased "over-the-counter". This form is required before OTC medications can be administered at school. Exceptions to this are homeopathic/herbal medications and OTCs not included in this list, which require completing the form "Permission to Give Prescription/Homeopathic Medication at School".

Please initial or check each over-the-counter medication for which you give your permission for your child to have at school, then sign below.

_____ I approve all medications listed below

Oral:

_____ Acetaminophen (Tylenol or generic substitute)
_____ Benadryl (Diphenhydramine)
_____ Claritin (Loratadine)
_____ Cough Syrup (Delsym/Robitussin)
_____ Ibuprofen (Motrin, Advil or generic substitute)
_____ Throat Lozenges
_____ Tums (Calcium Carbonate)
_____ Zyrtec (Cetirizine Hydrochloride)

Topical:

_____ Antibiotic Cream (Bacitracin)
_____ Benadryl Cream
_____ Burn Gel (Lidocaine)
_____ Contact Solution
_____ Saline Eye Solution
_____ Sunscreen
_____ Unscented Lotion
_____ Vaseline (Petroleum Jelly)

_____ I do not want *any* OTC meds given to my student

If this form is not returned to school, your child will not be given these medications. Please indicate if your child has an allergy or an unusual or unpleasant side effect to a specific generic or brand name medication. Please contact your school's health office with questions.

Allergies/side effects: _____

Additional comments: _____

I/we attest that I/we have a standing medical order from the student's healthcare provider that authorizes the administration of the above identified over-the-counter medications during the school year by the school nurse or nurse's designee.

It is understood that the medication is given solely at the request of, and as an accommodation to, the undersigned parent(s) or guardian(s). The undersigned parent(s)/guardian(s) hereby agree(s) to exempt and release the Elizabeth School District, its directors, officers, employees, volunteers, and agents from any and all liability, claims, demands or actions arising out of any damage, loss, or injury that my child or I/we sustain arising out of the administration of the non-prescription medication identified above to my child.

I have carefully read the information above and hereby authorize the school nurse or designee to administer the above medications during the current school year.

Signature of Parent/Guardian: _____

Date: _____

Name of Parent/Guardian: _____