



Student Health Information Form

20_____ - 20_____

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

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

Will your student be participating in school sponsored after school activities this school year (sports, clubs, before/after care)? Yes ___ No ___ If yes, which activities: _____

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 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 CONCERNS(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).

<input type="checkbox"/> Accidents/Injuries <input type="checkbox"/> ADD/ADHD (See below) <input type="checkbox"/> Allergies, Severe (See below) <input type="checkbox"/> Allergies, seasonal <input type="checkbox"/> Asthma (See below) <input type="checkbox"/> Autism <input type="checkbox"/> Behavior Concerns <input type="checkbox"/> Cancer/Leukemia Date Diagnosed: _____ Treatment Status: _____ <input type="checkbox"/> Developmental Delays	<input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Crohn's Disease/IBS <input type="checkbox"/> Cystic Fibrosis <input type="checkbox"/> Diabetes (See below) <input type="checkbox"/> Down Syndrome <input type="checkbox"/> Epilepsy/Seizures (See below) <input type="checkbox"/> Gastric Reflux/Ulcers <input type="checkbox"/> Glasses/Contacts <input type="checkbox"/> G-Tube or other type of feeding tube (requires tube feed authorization form)	<input type="checkbox"/> Hearing loss or aids <input type="checkbox"/> Head Injury/Concussion Date Diagnosed: _____ <input type="checkbox"/> Heart Conditions Type: _____ <input type="checkbox"/> Hemophilia/Bleeding Disorder <input type="checkbox"/> Immune Conditions <input type="checkbox"/> Mental Health Diagnosis (See below)	<input type="checkbox"/> Migraines/Headaches (See below) <input type="checkbox"/> Neuromuscular Disease <input type="checkbox"/> Orthopedic Disability <input type="checkbox"/> Daily Oxygen use (requires provider order) <input type="checkbox"/> Renal/Kidney/Bladder <input type="checkbox"/> Skin Conditions <input type="checkbox"/> Stomach/Intestines <input type="checkbox"/> Tracheostomy <input type="checkbox"/> Other: _____
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Further details(s) if needed:

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) _____ Date last reaction: _____ Type of reaction (difficulty breathing, hives etc.): _____
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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	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 _____

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)