# 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).

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

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**<br><br>Notify Nurse immediately if anaphylaxis may occur. | What is your child allergic to? _____<br>Is medication needed at school for allergies? Yes____ No ____ If yes, name: _____<br>Location of Medication:<br>Carried by student (**requires self-carry form**) _____ or Health Office (**requires anaphylaxis action plan**) _____<br>Type of reaction (difficulty breathing, hives etc): _____ |

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