** HEALTH INFORMATION**

# TO BE COMPLETED BY PARENT/LEGAL GUARDIAN EACH SCHOOL YEAR

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| **PART 1: PARENT OR LEGAL GUARDIAN TO COMPLETE. Parent/Legal Guardian is encouraged to participate in the development of an Individual Health Care Plan if needed. Use additional sheets, if necessary, for further explanation.**  |
| Name of School:   | Grade:  |
| Student’s Name: Last First M.I.  |
| Student’s Date of Birth:   | Sex: M F  | State or Country of Birth:  |
| Student’s Mailing Address:   | City:  | State:  | Zip Code:  |
| Student’s Physical Address:   | City:  | State:  | Zip Code:  |
| Name of Mother or Legal Guardian:  | Home Phone: ( )  | Work Phone: ( )  | Cell Phone: ( )  | Employer:  |
| Name of Father or Legal Guardian:  | Home Phone: ( )  | Work Phone: ( )  | Cell Phone: ( )  | Employer:  |
| Name of child’s pediatrician or primary care provider:   | Names of medical specialists or special clinics caring for your child:  |
|  Parent or Legal Guardian Signature Date**PART**  |
| In case of emergency—if parent or legal guardian cannot be reached—contact the following: Name Phone Number  ( ) |
| My child has a medical, mental, or behavioral condition that may affect his/her school day: No Yes (If yes, please complete Part 2.)  |
| **PART 2: COMPLETE ALL BOXES THAT APPLY TO YOUR CHILD.** Parent/Legal Guardian is responsible for providing the school with any medication and may be responsible for providing the school with any special food or equipment that the student will require during the school day. Check with the school nurse to obtain correct medication and procedure forms. |
| ❑ **ALLERGIES**  |
| Allergy Type:  Food (list food(s)) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Insect sting (list insect(s)) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Medication (list medication(s)) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Other (list) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reactions: (Date of last occurrence if yes.)  Coughing (Date: ) Hives (Date: )Rash (Date: )  Difficulty breathing (Date: ) Local swelling (Date: )Wheezing (Date: )   Generalized swelling (Date: ) Nausea (Date: ) Other \_\_\_\_\_\_\_\_\_(Date:\_\_\_\_) **Currently prescribed medications and treatments:**  Oral antihistamine(Benadryl, etc.)  Epi-pen  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| ❑ **ASTHMA**  |
| Triggers: Environmental (i.e., tobacco, dust, pets, pollen, etc.) (list) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other (list) \_\_\_\_\_\_\_\_\_\_\_\_ Does your child experience asthma symptoms with exercise? No  Yes Symptoms:  Chest tightness, discomfort, or pain Difficulty breathing Coughing Wheezing Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Currently prescribed medications and treatments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last hospitalization related to asthma \_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last emergency room visit related to asthma \_\_\_\_\_\_\_\_\_ Does your child have a written asthma management plan? No  Yes  Is peak flow monitoring used? No Yes  |

Page 1 of 2

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Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_

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| ❑ **DIABETES**  |
| **Currently prescribed medications and treatments:** Insulin:  Syringe  Pen  Pump  Blood sugar testing  Glucagon  Oral medication(s) List medication(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Is special scheduling of lunch or Physical Education required?  No  Yes  |
| ❑ **SEIZURE DISORDER**  |
| Type of seizure:  Absence (staring, unresponsive)  Complex Partial  Generalized Tonic-Clonic (Grand Mal/Convulsive)  Other (explain) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physical Education Restrictions:  No  Yes **Medication(s)*:***  No  Yes List medication(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last seizure \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Length of seizure \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| ❑ **OTHER HEALTH CONDITIONS**  (Circle all that apply) |
| Anemia ADD/ADHD Cancer  Cerebral Palsy  Chicken Pox  Cystic Fibrosis Depression  Digestive disorders Emotional/Psychological Juvenile Rheumatoid  Arthritis  Hemophilia Heart condition Physical disability  Sickle Cell Disease  Skin disorders Speech problemsOther (explain)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physical Education Restrictions:  No  Yes (explain): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Medication(s)*:***  No  Yes List medication(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Special procedures required** (i.e., catheterization, oxygen, gastrostomy care, tracheostomy care, suctioning):  No Yes (explain):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Special diet required** (i.e., blended, soft, low salt, low fat, liquid supplement): No  Yes (explain): \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Are there anticipated frequent absences or hospitalizations?** No  Yes (explain):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  ❑ **VISION CONDITIONS** | ❑ **HEARING CONDITIONS**  |
|  Contacts/glasses  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |  Hearing aid(s)  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| ❑ **ENVIRONMENTAL ADJUSTMENTS DUE TO A HEALTH CONDITION**  |
| **Special school environmental adjustments of the school environment or schedule:** No  Yes (explain):\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (i.e., seizures, limitations in physical activity, periodic breaks for endurance, building modifications for access) **Special school environmental adjustments to classroom or school facilities:** No  Yes (explain):\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (i.e., temperature control, refrigeration/medication storage) **Special safety considerations:** No  Yes (explain):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (i.e., special precautions in lifting, positioning, special transportation, emergency plan, special safety equipment, special techniques for positioning, feeding) **Special assistance with activities of daily living:** No  Yes (explain):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (i.e., eating, toileting, walking)  |
| **RETURN COMPLETED FORM TO SCHOOL NURSE/HEALTH OFFICE AS SOON AS POSSIBLE** |
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# Rev.7/2019 Page 2 of 2