STUDENT HEALTH INFORMATION 2016/2017

(Parent/Guardian to complete both sides)

Below please check any chronic conditions that your child has, list medications taken and answer the related questions. This information may be shared by the school nurse with school staff as needed to best serve your child while at school.

Student Name:		Birth Date:
Homeroom Teacher:		Grade:

Chronic Condition	✓ If Yes	List Medications/Time	Describe
ADD/ADHD			
Allergies Seasonal_____Environmental_____ Food_____ Other_____		Has your child ever had an anaphylactic reaction? Has this allergy been diagnosed by a physician? Has your child ever had to use an Epi-Pen?	To what? Type of reaction: Date of Epi-Pen use:
Arthritis			
Asthma			Date of last Episode: Known Triggers:
Autism/Asperger's Disease			
Cancer			Type: Undergoing Treatment or in Remission
Cerebral Palsy			Walking Aid:
Cystic Fibrosis			
Diabetes			Insulin via: Pump or Injection
Down's Syndrome			
Epilepsy/Seizures		Date of last seizure: Medication:	Diastat? Yes or No Date of last use:
Frequent Ear Infections			Tubes? Yes or No
Headaches/Migraines			How frequent? Triggers:
Hearing Problems			Hearing Aid Worn: Left Right Cochlear Implant: Yes or No
Heart Condition			Specify:
Hemophilia			
High Blood Pressure			
Immunizations		Has your child received childhood immunizations?	Yes or No
Kidney or Bladder Problems			Specify:
Menstrual Problems			Specify:
Multiple Sclerosis Muscular Dystrophy			Walking Aid:
Nosebleeds			Frequency:
Orthopedic Problems			Specify: Walking Aid:
Psychological Disorder		Does your child see a therapist? Yes or No	Specify:
Sickle Cell Disease			
Skin Problems/eczema, abnormal skin pigmentations (café-au-lait, hemangiomas, mongolian spots, etc.)			Specify:
Spina Bifida			
Stomach Problems			Specify:
Vision Problems		Date of last eye exam:	Wears: Glasses or Contacts For: Reading Only or All School Work
Head Injury/Concussion		Has your child suffered from a head injury or concussion in the past year?	Specify:

★ **Will your child need to take medication during the school day? Yes or No (Includes Inhalers, Epi-Pens, Diastat, and Glucagon)**

If **yes**, please see the medication policy in the parent handbook and contact your school nurse to request a medication authorization form.

My child has no health problems._____Initial please

PLEASE COMPLETE THE REVERSE SIDE OF THIS FORM BEFORE RETURNING

Revised 6/8/2016