SCHOOL HEALTH INFORMATION

Name:_____ **Birthdate**:_____/_____/_____ **Sex:** M F **Grade:**_____

Guardian Name:_____**Primary Phone**:_____**Alternative Phone:**_____

Email:_____ **Case Manager (if applicable)**:_____

School: ***Futures/CHOICE/Connections*** ***Area Learning Center*** ***Transition 2 Success***

HEALTH CONDITIONS [*Check any of the following health condition(s) your child has*]

☐ **ADD** ☐ **ADHD** ☐ Medication at home:_____ ☐ Medication at school:_____	☐ **Allergies:** List:_____ ☐ Medication at home:_____ ☐ Medication at school:_____ **Anaphylactic (life threatening) Reaction** ☐ Yes ☐ No **Epi-Pen** ☐ Yes ☐ No
☐ **Asthma** *Triggers*: ☐ Exercise ☐ Allergies ☐ Colds ☐ Other: ☐ My child has an Asthma Action Plan ☐ My child has used asthma medications in the last 2 years. ☐ Medication at home_____ ☐ Medication at school_____ Last Episode_____ Last Hospitalization for Asthma_____	☐ **Mental Health concerns/diagnosis:** Describe:_____ Medication:_____
☐ **Headaches-Frequent/severe** ☐ **Migraine** ☐ Medication at school List:_____	☐ **Seizures/Convulsions** **Type:**_____ Medication:_____ Last known:_____
☐ **Bone or joint concern**	☐ **Dental/Orthodontic concerns**
☐ **Diabetes** Medication required ☐ Yes ☐ No Type:_____	☐ **Ear/Hearing concerns** Hearing aid ☐ yes ☐ no ☐ left ear ☐ right ear ☐ both
☐ **Food restrictions/Special diet**	☐ **Heart/cardiovascular Conditions**
☐ **Frequent/severe Kidney/Bladder conditions**	☐ **Learning concerns**
☐ **Lung/Breathing concerns**	☐ **Pain/Discomfort--frequent/severe**
☐ **Permanent or long-term disability**	☐ **Serious injury** Describe:_____
☐ **Skin Concerns**	☐ **Stomach or digestive concerns**
☐ **Weight concerns/Eating disorder**	☐ **Other:**_____

For any conditions checked above, please specify the current status, treatment, medication, care and history.

_____

_____

Eye/Vision concerns? ☐ Yes ☐ No
Does child wear glasses/contacts? ☐ Yes ☐ No **Are they to be worn at school?** ☐ Yes ☐ No

Date of last professional exam:_____/_____/_____ **Results**:_____

Does child have any activity restrictions? ☐ Yes ☐ No

Is child taking any medication not listed above? ☐ Yes ☐ No ☐ Home ☐ School Specify:_____

Would you like to meet with the school nurse to discuss any further concerns? ☐ **Yes** ☐ **No** **Concern:**_____

The school intends to use the requested information to provide for your child's health and safety needs while at school. You may refuse to supply the requested personal information. There will be no consequence for not providing the information. It may result in an incomplete health and safety plan for your child. The information you provide will be shared only with staff in the school whose jobs require access to this information to ensure your child's safety and school success.

FOR HEALTH OFFICE USE:

Reviewed by:_____
Date Reviewed:_____
Charted by:_____
Date Charted:_____

_____ _____
Signature of Parent/Guardian **Date**