STUDENT HEALTH INFORMATION FORM 2019-2020

Student Name: _____Grade _____ DOB_____

Student Address: _____ City _____ Zip_____

Parent/Guardian Name: _____ Contact Name and Phone Number 1: _____
Contact Name and Phone Number 2: _____

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Does your child have: (circle correct response)

Earaches Y N **Headaches** Y N **Dizziness/Blackouts** Y N **Nosebleeds** Y N

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List all MEDICATION your child is currently taking: (**at home or at school- including dose, time and reason**)

1._____ 4. _____
2._____ 5. _____
3._____ 6. _____

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PARENT TO PROVIDE DOCTOR SIGNED CARE PLAN ANNUALLY

Conditions requiring a CARE PLAN: Allergies, Asthma, Bee Sting, Cardiac, Diabetes, Epilepsy (Seizures)

See NWCS website for CARE PLAN forms. Click on school then Clinic/Nurse. Forms located top right.

Does your child have: (circle correct response)

Diabetes Y N ***Epilepsy/Seizures*** Y N ***Heart Condition*** Y N

Asthma Y N If YES- is an Inhaler needed? Y N ***Care plan required ONLY if circled Y for inhaler***

*Students **MUST** have Care Plan and Parent note signed to use inhaler at school. Please take both forms and inhaler to clinic.

Bee Sting Y N If YES- is an Epi pen needed? Y N ***Care plan required ONLY if circled Y for Epi pen***

ALLERGIES- If you answer YES to Epi pen needed- YOU MUST fill out a CARE PLAN titled- Emergency Allergic Reaction

List known: **ALLERGY**:_____ **REACTION:**_____ **Epi pen Needed** Y N
List known: **ALLERGY**:_____ **REACTION:**_____ **Epi pen Needed** Y N

The school requires a doctor's note stating a milk allergy.

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Has your child had surgery: Y N *If you circled Yes: Date of surgery _____
Type of surgery _____
Dietary restrictions: Y N *If you circled Yes: Type of restriction_____

List all immunizations received within the past year including **DATE ISSUED:** (Applicable for K, 6th grade & 12th grade)

1._____2._____3._____4._____5._____

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Physician's Name _____ Phone # _____ Hospital preferred _____
Psychiatrist/ Psychologist/ Therapist: Name _____ Phone _____

IN CASE OF SERIOUS ILLNESS OR ACCIDENT, I AUTHORIZE THE SCHOOL TO TAKE WHATEVER ACTION NECESSARY AND GIVE PERMISSION TO TRANSPORT MY CHILD TO THE HOSPITAL IF NECESSARY.

IT IS THE PARENTS RESPONSIBILITY TO NOTIFY THE SCHOOL, IN WRITING, OF ANY CHANGES DURING THE SCHOOL YEAR.

_____ _____

Date **Parent/ Guardian signature (must be signed)**

***Health information will be accessible to staff to ensure the health and safety of your child on an as needed basis. If you do not wish any information to be distributed, you must notify the school in writing.** Revised 3/2017