**Ossian Elementary School '18-'19**
**Student Health Information**

Please fill out this form ***completely***. This form is to be filled out on a yearly basis.

**BE SURE TO SIGN THE BOTTOM LINE**

Student's Name: ______________________ Date of birth: ____________ Grade: K

Does your child have? (Please circle the correct response):

| | | | | | |
|---|---|---|---|---|---|
| Frequent colds | Yes | No | Fainting Spells | Yes | No |
| Asthma | Yes | No | Heart Condition | Yes | No |
| Earaches | Yes | No | Headaches | Yes | No |
| Diabetes | Yes | No | Rheumatic Fever | Yes | No |
| Seizure Disorder | Yes | No | Dizziness or blackouts | Yes | No |
| Epilepsy | Yes | No | Frequent Nosebleeds | Yes | No |
| Bee Sting Allergy | Yes Mild or Severe | No | | | |

Does your child have allergies? Yes No If yes, please specify: ______________________

______________________________________________

Does your child have asthma? Yes No If yes, list medication(s): ______________________

______________________________________________

Is your child on medication? Yes No If yes, list medication(s): ______________________

______________________________________________

Reason for taking medication: ______________________________________________

Has your child had any surgeries? Yes No If yes, specify what kind of surgery and the date(s): ______

______________________________________________

Does your child have a medical problem that would require us to follow a specific procedure in the case of an emergency situation? Yes No If yes, please specify the procedure in the order it is to be performed:

______________________________________________

______________________________________________

______________________________________________

Are there any eating habits or dietary restrictions that the school should be aware of? Yes No If so, please list: ______________________________________________

______________________________________________

(If your child has a milk allergy, the school requires a doctor's note stating a milk allergy exists.)

Please add any additional information that might help us in protecting your child's health: ____________

______________________________________________

______________________________________________

Physician's Name: ______________________ Phone Number: ______________

Hospital Preferred: ______________________

In case of serious illness or accident, I authorize the school to take whatever action is necessary and give my permission to transport to the hospital, if necessary.

____________ ______________________________

***Date*** ***Parent or guardian signature (must be signed)***

This information will be accessible to staff members to insure the health and safety of your child. If you do not wish this information to be distributed, you must notify the school in writing.

**IT IS THE PARENT'S RESPONSIBILITY TO NOTIFY THE SCHOOL, IN WRITING, OF ANY CHANGES DURING THE SCHOOL YEAR.**

# CHIRP

## Children and Hoosiers Immunization Registry Program

Northern Wells Community Schools participates in CHIRP, a free and innovative online system that scores and updates immunization records of both children and adults in Indiana. The State of Indiana now requires all public school systems to gather this information each year. It is confidential and free.

I give Northern Wells Community Schools Nurses permission to register my student's immunization records onto the Indiana State Department of Health's Children and Hoosiers Immunization Registry Program (CHIRP).

I understand that the information in the registry may be used to verify that my student has received proper immunizations and to inform me of my student's need to be vaccinated according to recommended immunization schedules.

I hereby consent to the release of such information.

Signature                                        Date

Printed Name of Parent / Guardian

Student's Name                                        Date of Birth