STUDENT HEALTH INFORMATION FORM

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 **Nose Bleeds** 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 NHS then NHS 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 exists so that your child may have soy milk.

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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.

Health information will be accessible to staff to ensure the health & safety of your student on an as-needed basis. If you do not wish any information to be distributed, you must notify the school in writing.

Revised 3/2018

_____ _____

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