HEALTH INFORMATION FORM

THIS FORM MUST BE filled out and SIGNED BY a parent and SUBMITTED TO THE SCHOOL NURSE prior to the start of school.

NAME _____**BIRTH DATE** _____**SEX**____**GRADE** _____**Year**_____
Parent(s)/Guardian(s): _____Phone #1_____Phone #2_____
Family Physician _____Phone_____
Family Dentist _____ Phone _____

Student Health Concerns

Yes/No_____ My child *has been diagnosed with or has experienced* the following conditions
Yes/No_____ My child *receives regular medical/ health care* for the following conditions.

(Please all that may apply)

____ ADD/ ADHD
____ Autism
____ Behavior/ Emotional Concerns
____ Blood/Bleeding Problems
____ Bone/Muscle/ Joint Problems
____ Bowel and/or Bladder Problems
____ Cancer
____ Concussion (past)/Traumatic Brain Injury
____ Cystic Fibrosis
____ Depression
____ Diabetes
____ Digestive (stomach) concerns/gastric reflux
____ Headaches/Migraines
____ Heart Problems (current or history of heart problems)
____ Scoliosis
____ Seizure Disorder
____ Sickle Cell Anemia
____ Skin Conditions (eczema, infections, reactions to insects, etc.)
____ Surgery/Hospitalizations (past/current)
____ Other_____

Please explain any conditions above. Use back of form if needed.
_____

If there are special concerns, medications, treatments, or potential risk problems are an indication for your child, the school nurse or designated staff will contact you.

1. EYE/ EAR/ NOSE/ THROAT: Does your child have (Yes or No)

____ Vision problems? Explain: _____
____ Glasses? When does your child need to wear them? _____
____ **History** of ear infections? Ear tubes? **Y/N** _____
____ Any hearing loss? If so, does it affect classroom performance, participation at recess or in PE? Explain_____

2. RESPIRATORY: Has your child experienced or been diagnosed with (Yes or No)

____ **Asthma** or reactive airway? At what age? _____ Does your child use medication? **Y/N** _____ (if yes please list below)
____ Will your child need medication(s) at school? **Y/N**_____ (if yes, see diocese/school medication policy)

3. ALLERGIES:

- Allergies to medication(s)_____ *Animal(s)*_____ *Seasonal*_____
- Allergies Food(s)_____Severe **Y/N**_____
- Does your child have Emergency medication? **Y/N**_____ and does your child have a need for medication at school? **Y/N** _____(if yes please list below)

List prescription and over the counter medications your child takes regularly at home. (Medication name, amount, time)

_____
_____

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- ***All PK/PS, Kindergarten and new students*** *must supply copy of current/updated immunization record prior to start of school.*
- ***Current students*** **(6th-8th)** *if received Tdap and meningococcal booster (required by start of 8th grade), copy of updated immunization record must be sent prior to start of school.*
- ***Current students*** *(1st-5th) if there are any updates/boosters received, a copy of the updated immunization record must be sent to school.*

I understand that only pertinent information regarding my child's condition may be shared with school staff who are directly involved with my child and his/her care in the school setting.

Parent Signature_____ Date_____

I **do not** want this information shared with staff who are directly involved with my child and his/her care in the school setting.

Parent Signature_____ Date_____

Revised April 2017