

# Request for Health Information

Date: \_\_\_\_\_

Must be completed annually

Please return the following form to your child's teacher **as soon as possible**. This information will be reviewed by the School Nurse.

|  |                    |                   |
|--|--------------------|-------------------|
| School:  | Grade:             | Homeroom Teacher: |
| <b>STUDENT NAME:</b>   | Date of Birth:     | Bus#              |
| Parent/Guardian:   | Daytime Phone (1): |                   |
| Parent/Guardian email:   | Daytime Phone (2): |                   |
| Emergency Contact:   | Phone:             |                   |
| Current Doctor/Practice:   | Phone:             |                   |
| <b>Medication allergies and reaction(s):</b> <input type="checkbox"/> NONE KNOWN <input type="checkbox"/> Yes (list):  |                    |                   |
| Current Medications:   |                    |                   |
| <b>Meds needed at school?:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes* (list): <i>(*)Medication consent form is required to be signed by the health care provider and the parent/guardian. Medication cannot be given until consents have been received.</i> |                    |                   |

**CHECK THE CONDITION(S) YOUR CHILD HAS BELOW, OR**

**MY CHILD HAS NO KNOWN HEALTH CONDITIONS**

(You may stop here if there are no known medical conditions. Please sign at the bottom and return form).

|   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> <b>ADD/ADHD</b><br>(See Below)<br><input type="checkbox"/> <b>Allergies, Severe</b><br>(See Below)<br><input type="checkbox"/> Allergies, Seasonal<br><input type="checkbox"/> <b>Asthma</b> (See Below)<br><input type="checkbox"/> Autism<br><input type="checkbox"/> Cancer/Leukemia<br>Date Diagnosed: _____ | <input type="checkbox"/> Cerebral Palsy<br><input type="checkbox"/> Crohn's Disease/IBS<br><input type="checkbox"/> Cystic Fibrosis<br><input type="checkbox"/> <b>Diabetes</b> (See Below)<br><input type="checkbox"/> Down Syndrome<br><input type="checkbox"/> <b>Epilepsy/Seizures</b><br>(See Below)<br><input type="checkbox"/> Glasses/Contacts | <input type="checkbox"/> Hearing Aid/Loss<br><input type="checkbox"/> <b>Head Injury/Concussion</b><br>Date Diagnosed: _____<br><input type="checkbox"/> Heart Conditions<br>Type: _____<br><input type="checkbox"/> Hemophilia/Bleeding Disorder<br><input type="checkbox"/> <b>Mental Health Diagnosis</b><br>(See Below)<br><input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Neuromuscular Disease<br><input type="checkbox"/> Orthopedic Disability<br><input type="checkbox"/> Renal/Kidney Disease<br><input type="checkbox"/> Juvenile Rheumatoid Arthritis<br><input type="checkbox"/> Sickle Cell Anemia<br><input type="checkbox"/> Ulcers/Gastric Reflux<br><input type="checkbox"/> Other: _____ |
|---|--|--|---|

**FOR THE FOLLOWING CONDITIONS, PLEASE PROVIDE ADDITIONAL INFORMATION:**

|  |  |
|--|--|
| <b>Severe Allergies</b><br><br>Notify your School Nurse <b>IMMEDIATELY</b> if anaphylaxis may occur. | What is your child allergic to? <input type="checkbox"/> Peanuts <input type="checkbox"/> Tree Nuts <input type="checkbox"/> Milk <input type="checkbox"/> Eggs <input type="checkbox"/> Insect Stings<br><input type="checkbox"/> Other: _____<br><br>Is medication needed at school for allergies? <input type="checkbox"/> No <input type="checkbox"/> Yes*<br>If yes, name: _____<br>Location of Medication: <input type="checkbox"/> Carried by student* ( <b>requires self-carry form</b> ) <input type="checkbox"/> Classroom <input type="checkbox"/> Health Room<br>Date/Type Last Reaction: _____ Check the type of allergic reaction that occurs:<br><input type="checkbox"/> HIVES <input type="checkbox"/> SWELLING <input type="checkbox"/> DIFFICULTY BREATHING <input type="checkbox"/> OTHER: _____ |
| <b>Asthma</b>  | Is medication needed at school for asthma? <input type="checkbox"/> No <input type="checkbox"/> Yes*<br>If yes, name: _____<br>Location of Medication: <input type="checkbox"/> Carried by student* ( <b>requires self-carry form</b> ) <input type="checkbox"/> Classroom <input type="checkbox"/> Health Room<br>Date of last episode: _____<br>Triggers: <input type="checkbox"/> Environmental <input type="checkbox"/> Seasonal <input type="checkbox"/> Exercise induced <input type="checkbox"/> Upper respiratory infection <input type="checkbox"/> Other: _____  |
| <b>Epilepsy/Seizures</b>   | Type: <input type="checkbox"/> Febrile Only <input type="checkbox"/> Convulsive <input type="checkbox"/> Non-Convulsive Date of last seizure: _____<br>Is emergency medication needed at school? <input type="checkbox"/> No <input type="checkbox"/> Yes*<br>If yes, name: _____  |
| <b>Diabetes</b>  | Type I <input type="checkbox"/> Type II <input type="checkbox"/> Diagnosis Date: _____<br>* <b>Insulin</b> by: <input type="checkbox"/> Pump <input type="checkbox"/> Injections <b>CGM</b> (i.e.: Dexcom): <input type="checkbox"/> No <input type="checkbox"/> Yes, Type: _____<br><b>Please call to schedule Nurse Conference - Notify your school nurse immediately if newly diagnosed</b>   |
| <b>ADD/ADHD Mental Health</b>  | Type: <input type="checkbox"/> ADD <input type="checkbox"/> ADHD <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Other: _____<br>Medication used for treatment: _____  |

Please be aware that the information you provide will be shared with staff on a need-to-know basis.

In the event of an emergency, and you cannot be reached, I give permission for the School Nurse to contact my doctor for further instructions on medications or care.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date