

Request for Health Information

Must be completed annually

Date: _____

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:
STUDENT NAME:	Date of Birth:	Bus #:
Parent/Guardian:	Daytime Phone (1):	
Parent/Guardian email:	Daytime Phone (2):	
Emergency Contact:	Phone:	
Current Doctor/Practice:	Phone:	
Medication allergies and reaction(s): <input type="checkbox"/> NONE KNOWN <input type="checkbox"/> Yes (list):		
Current Medications:		
Medications needed at school?: <input type="checkbox"/> No <input type="checkbox"/> Yes* (list):		
<p>(*) 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. Consent form will be provided upon request.</p>		

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

Severe Allergies	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 <input type="checkbox"/> Other: _____ Is medication needed at school for allergies? <input type="checkbox"/> No <input type="checkbox"/> Yes* If yes, name: _____ Desired Location of Medication: <input type="checkbox"/> Carried by student* (requires self-carry form) <input type="checkbox"/> Classroom <input type="checkbox"/> Health Room Date/Type Last Reaction: _____ Check the type of allergic reaction that occurs: <input type="checkbox"/> Hives <input type="checkbox"/> Swelling <input type="checkbox"/> Difficulty Breathing <input type="checkbox"/> Other: _____
Asthma	Is medication needed at school for asthma? <input type="checkbox"/> No <input type="checkbox"/> Yes* If yes, name: _____ Desired Location of Medication: <input type="checkbox"/> Carried by student* (requires self-carry form) <input type="checkbox"/> Classroom <input type="checkbox"/> Health Room Date of last episode: _____ Check what is likely to cause an asthma flare: Triggers: <input type="checkbox"/> Environmental <input type="checkbox"/> Seasonal <input type="checkbox"/> Exercise induced <input type="checkbox"/> Upper respiratory infection <input type="checkbox"/> Other: _____
Epilepsy/Seizures	Type: <input type="checkbox"/> Febrile Only <input type="checkbox"/> Convulsive <input type="checkbox"/> Non-Convulsive Date of last seizure: _____ Is emergency medication needed at school? <input type="checkbox"/> No <input type="checkbox"/> Yes* If yes, name: _____
Diabetes	Type I <input type="checkbox"/> Type II <input type="checkbox"/> Diagnosis Date: _____ * Insulin by: <input type="checkbox"/> Pump <input type="checkbox"/> Injections CGM (i.e.: Dexcom): <input type="checkbox"/> No <input type="checkbox"/> Yes, Type: _____ <i>Please call to schedule Nurse Conference - Notify your school nurse immediately if newly diagnosed</i>
ADD/ADHD Mental Health	Type: <input type="checkbox"/> ADD <input type="checkbox"/> ADHD <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Other: _____ Medication(s) 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