Health/Nursing Services
Student Health Information & Consent for Treatment

FOR OFFICE USE ONLY
Teacher:_____ Bus #_____

Please report changes in your child's health information to the school. Please complete *both* sides of the form.

Student LAST Name (Legal)	Student FIRST Name (Legal)	Student MIDDLE Name (Full)	Grade Enrolling In
Date of Birth	Date of Last Well-Child Check or Physical Examination:	Date of Last Visit to a Dentist:	☐ Male ☐ Female

Physician Name:			Dentist Name:			
Vision Care Provider:			Other Health Provider/Specialist:			
Health Insurance:	☐ None	☐ Military	☐ Indian Health	☐ Private	☐ Medicaid	☐ Centennial Care
Policy Holder:			Policy or Group Number:			
Health Insurance/Provider Name :						
☐ Prescribed (Rx) medications are taken			List Rx Medications:			
☐ Over-the-Counter (OTC) medications are taken/needed			List OTC Medications:			

Does your child need Rx medication or OTC medication during school, school activities, or field trips? ☐ Yes ☐ No
Does your child need Rx medication or OTC medication on *overnight* field trips? ☐ Yes ☐ No
If *Yes*, please list name of medication(s):

If Yes, please contact the school nurse to obtain the **required** parent and/or medical authorization (orders) forms.

✓ Student Medical History and Current Status (check all that apply)

Please provide information about your child's health and identify if your child has any **medically diagnosed** condition(s). Please provide **medical documentation** of diagnoses and/or consider obtaining medical records if the diagnosis impacts your child's learning.

☐ ADD ADHD (circle one)
Intervention(s):_____

☐ Asthma ☐ Past History of Asthma
Date asthma last evaluated by physician:_____
☐ Inhaler needed for school
☐ Nebulizer needed for school
☐ Controller medication(s):_____

☐ Bladder incontinence/accidents ☐ Voiding schedule ☐ UTIs

☐ Bowel incontinence/accidents ☐ Constipation

☐ Diabetes: Type I Type II Pre-diabetes (circle one)

☐ Emotional/Social Concerns (circle)
Friends Avoids school Behavior Numerous changes Grief
Explain:_____

☐ Glasses ☐ Contact lenses
Date of last vision exam _____

☐ Head Injury ☐ Concussion Date: _____
Please provide medical documentation if medically diagnosed

☐ Hearing Loss
☐ Hearing Aides ☐ Amplification
☐ Frequent Ear Infections ☐ PE tubes are currently in place

☐ Heart Problems:_____

☐ Migraine ☐ Migraine medication:_____

☐ Psychological/Behavioral disorder
☐ Anxiety ☐ Self-Harm (cutting) ☐ Threatening Others
☐ Depression ☐ Suicide Attempt
☐ Other:_____
☐ Receives behavioral health care (counseling, medication)
Provider name:_____
Date of last appointment/session:_____

☐ **Other, not listed:**_____

☐ Pregnant or parenting student

☐ Scoliosis ☐ Wears device ☐ Has activity restrictions

☐ Seizures Type: _____
☐ Emergency seizure medication(s) needed:_____

✓ Student Medical Allergy Information

Check if *Yes*	Allergy Category	Life-Threatening (anaphylaxis)	Has Injectable Epinephrine	Specific Allergy (penicillin, peanuts, cats, etc.)	Type of Reaction (rash, itching, sneezing, runny nose, minor swelling, stomach ache, etc.)
☐	Drug Allergy	☐ YES	☐ YES		
☐	Food Allergy	☐ YES	☐ YES		
☐	Bee/Wasp Allergy	☐ YES	☐ YES		
☐	Insect Allergy	☐ YES	☐ YES		
☐	Animal Allergy	☐ YES	☐ YES		
☐	Pollen Allergy (Seasonal)	☐ YES	☐ YES		
☐	Latex Allergy	☐ YES	☐ YES		
☐	Other Allergy	☐ YES	☐ YES		

BIRTH HISTORY- Complete as much as possible

1. Birth Weight:_____ Birth Length:_____ Age in weeks at birth: _____ Premature☐ Full Term☐ Post Term☐
2. Difficult pregnancy (i.e., pre-term contractions, bleeding, illness/infection, eclampsia, pregnancy related diabetes):
   Y☐ N☐ If Y, explain: _____
3. Medications/drugs taken during the pregnancy: None ☐ Over the Counter☐ Prescription☐ Alcohol☐
   Street Drugs☐ Explain reason for medications: _____
4. Did student have problems after birth (e.g. difficulty breathing, yellow skin)? Y☐ N☐
5. Did student receive special care after birth? Y☐ N☐ Explain: _____
6. Length of birth hospital stay:_____ Explain:_____

DEVELOPMENTAL HISTORY- Complete as much as possible

1. Has the student *ever* received Physical, Occupational, Speech/Language therapy? Y ☐ N ☐
   If Y, explain:_____
2. Are you or has anyone ever been concerned about the student's growth OR development? Y☐ N☐
   If Y, explain:_____
3. At what age did your child: Walk alone_____ Talk in sentences_____ Complete Toilet training _____

HEALTHY HABITS-Update with changes

Sleep – Number of hours of sleep the student gets most nights: _____ Normal bedtime: _____
Student falls asleep easily. Y ☐ N☐ Student wakes up easily. Y☐ N☐
Student wakes up rested. Y☐ N☐ Student's sleep is: ☐sound ☐restless.
Student has a usual bedtime *routine*. Y☐ N☐ Student sleeps in his/her own bed. Y☐ N☐

Student: ☐snores ☐ wets his/her pants or wets the bed ☐ has other sleep issues
Explain:_____

Energy Balance – Student eats at least 3 meals each day Y☐ N☐ Student ☐eats most foods ☐is a picky eater
Do you have any concerns about student's eating? Y☐ N☐ (Explain)
Do you have any concerns about student's physical activity/exercise? Y☐ N☐ (Explain)

If Y, explain:_____

This parent/legal guardian signed form enables school officials to obtain emergency medical treatment for a student who is a minor, when no parent/legal guardian can be reached, after reasonable attempts have been made. This authorizes emergency personnel, and medical and dental care providers to give reasonable and customary health care, deemed necessary by school personnel, for the named student in the absence of parents/guardians or designated emergency contacts. It also authorizes transport and medical treatment by appropriate and available substitute providers in the event preferred providers are unavailable. The information provides a health history to the school and emergency medical providers to determine a plan of care while at school and in an emergency. It also gives parental authorization for prescription and/or over the counter medications to be taken under the supervision and determination by the School Nurse per procedures. The signed form releases the liability of any school official or employee who, in good faith, attempts to comply with this consent and deems the parent/guardian financially responsible for all emergency care and services administered to the referenced child. The parent/guardian is responsible for providing updates in writing for any changes to the contact persons, phone numbers, or information provided on this form.

Parent/ Legal Guardian Name (please print) : _____

Parent/Legal Guardian Signature: _____ Date: _____