



PLEASE PRINT CLEARLY

Date \_\_\_\_\_

Student Name \_\_\_\_\_ Grade Level \_\_\_\_\_

The following information is important for your student's health and safety. It will be forwarded to the school nurse.

I acknowledge that this information may be shared with other school staff on a need-to-know basis to provide a safe and healthy environment for my student.

I prefer to speak with a school nurse directly regarding the following information.

Please contact me by telephone at this number: (\_\_\_\_\_) \_\_\_\_\_

HEALTH INFORMATION

Does your child have a LIFE-THREATENING HEALTH CONDITION?  Yes  No

A LIFE-THREATENING CONDITION is a health condition that will put the child in danger of death during the school day if a medication or treatment order and a nursing plan are not in place. Children with LIFE-THREATENING CONDITIONS such as severe bee sting or severe food allergies, severe asthma, diabetes, severe seizures, or other at-risk conditions are required to have a medication or treatment order and a nursing plan in place before they start school. Please notify office staff at registration; you will need to contact your building nurse (Educational Health Specialist) before your student can attend school.

Does your student have medical insurance?  Yes  No If so, what kind? \_\_\_\_\_

Check any of these conditions which your child has or has had

- |                                 |                                         |                                               |                                                 |                                                      |
|---------------------------------|-----------------------------------------|-----------------------------------------------|-------------------------------------------------|------------------------------------------------------|
| <input type="checkbox"/> ADD    | <input type="checkbox"/> Diabetes       | <input type="checkbox"/> In Counseling        | <input type="checkbox"/> Heart Disease          | <input type="checkbox"/> Social/Emotional/Behavioral |
| <input type="checkbox"/> ADHD   | <input type="checkbox"/> Bowel Concerns | <input type="checkbox"/> Convulsions/Seizures | <input type="checkbox"/> Kidney/Bladder Disease | <input type="checkbox"/> Vision Problems             |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Cancer         | <input type="checkbox"/> Hearing Problems     | <input type="checkbox"/> Orthopedic/Bone        |                                                      |

Other: Please Specify: \_\_\_\_\_

Allergy to: \_\_\_\_\_ Severe?  Yes  No

Asthma Severe?  Yes  No Hospitalized?  Yes  No

What triggers your student's asthma (for example: exercise, upper respiratory infections, allergies, emotions, etc.)? \_\_\_\_\_

Which of the above conditions have been diagnosed by a medical doctor? \_\_\_\_\_

Licensed Health Provider Name: (e.g. M.D., D.O., A.R.N.P., P.A., etc.) Name: \_\_\_\_\_

Contact Phone Number: (\_\_\_\_\_) \_\_\_\_\_

What does this student do to manage his/her own condition? \_\_\_\_\_

How can the nurse/teacher help with this at school? \_\_\_\_\_

What symptoms should we report to you? \_\_\_\_\_

If this student must receive medication while at school, an AUTHORIZATION FOR MEDICATION form must be completed and signed by the attending physician and parent(s) or legal guardian(s) of the student (chapter 195-182). You can obtain this form from the school secretary.

Medication Taken: \_\_\_\_\_ For \_\_\_\_\_  At Home  At School

Medication Taken: \_\_\_\_\_ For \_\_\_\_\_  At Home  At School

Provide any information not included above which you think we should know about this student's physical, emotional, or mental health which might affect school performance or require special consideration (i.e. limitations in activities, major life events, etc.).

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature of Parent / Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_ Permission for hearing test?

Yes  No