

HEALTH SERVICES REGISTRATION Pre-K - 12

School Year _____

Student's Name: _____
Last First Middle

Date of Birth: _____ Grade: _____
Language: _____

HEALTH CONCERNS/HEALTH HISTORY:

← Check here if your child **DOES NOT** have any health issues (*sign at bottom*)

If your child has health concerns please check all current health conditions below and fill in blanks if applicable. Parent/guardian is responsible for notifying the school of new or existing health concerns and for providing the school with any medication or equipment that the student will require during the school day. Check with the health office to obtain the correct procedural forms. ****Life-threatening conditions such as anaphylaxis, asthma, diabetes, or other conditions require individual health care plans/action plans, medication permits, and staff training prior to the first day of school. Please contact the school nurse to discuss your child's needs.***

ALLERGIES (**requires an Allergy Action Plan if intervention is needed at school and a medication permit if medication will be kept in health office*)

Food: _____ Bee / Insect: _____ Allergy to Medication: _____ Other: _____
School Treatment: My child will carry EpiPen & has been instructed on EpiPen use EpiPen will be kept in Health Office* Other: _____

ASTHMA (**requires an Asthma Action Plan if intervention is needed at school and a medication permit if medication will be kept in health office*)

Triggers: Exercise Environmental Other: _____
School Treatment: My child will carry inhaler & has been instructed on inhaler use Inhaler/Nebulizer will be kept in health office*
 My child was diagnosed with asthma but no longer uses an inhaler - date of last asthma episode: _____

DIABETES (**a Diabetes Care Plan is required for all students with Type I Diabetes - please contact the school nurse prior to the start of school*)

*Type I (takes insulin) Insulin Pump Pen Syringe Type II (diet/exercise/medication controlled)

EMOTIONAL/BEHAVIORAL/PSYCHOLOGICAL/DEVELOPMENTAL

ADD ADHD Anxiety Asperger's Autism Bipolar Depression Developmental Delay
 Mood Disorder OCD ODD PTSD Schizophrenia Other: _____

HEARING/VISION

Known hearing loss *explain:* _____ Hearing aid Glasses/Contacts Other vision problem: _____

MOBILITY/ACTIVITY

Activity restriction *explain:* _____ My child uses an assistive device: Wheelchair Walker Other: _____

SEIZURES (**please contact the school regarding a seizure action plan and a medication permit if medications will be given at school*)

Type of seizure: _____ Date of last seizure: _____ My child will have Diastat at school*

OTHER MEDICAL ISSUES (*if you check any conditions below please explain in space provided*)

Bleeding disorder Birth defect/disorder Cancer Cerebral Palsy Concussion (date: _____) Endocrine
 Gastrointestinal/Bladder Skin condition Heart Condition Hypertension Migraines Other: _____
Explanation: _____

My child will need help with activities of daily living and/or health care procedures (**contact nurse*)

MEDICATION (**obtain medication permit from health office at school*)

Medication taken at home: _____
 Medication to be given at school (**permit required*): _____

Information provided on this form will replace and/or update any previous health information received with the exception of Life-Threatening Health Conditions (*contact nurse about removing this information*). It is the parent/guardian responsibility to notify the health office if any changes occur in their child's health status.

Parent/Guardian Name (printed): _____ Parent/Guardian Signature: _____ Date: _____