East Carter R-2 School District
Health Inventory
2016-2017 SY

Your child's learning depends upon good health . To assist us in providing health services for your student, please complete the following inventory and return to Health Office.

Student_____Birthdate_____Grade_____Teacher_____
Health Ins Name:_____Policy #_____
Primary DR:_____PH#_____
Hospital preference_____
In the case of an emergency, may the student be transported by EMS? Yes__ NO__

MY STUDENT HAS: NO HEALTH CONCERNS (CIRCLE IF THIS APPLIES)

Asthma	yes	no	If **yes**, please contact the school nurse for the Asthma health history form/Emergency Plan
Blood sugar concerns (Diabetes or Hypoglycemia)	yes	no	If **yes**, please contact the school nurse for the Diabetes health history form/Emergency Plan
Allergies Type: Drug, food, insect, environmental, other_____	yes	no	mild_____Life threatening____local reaction____ Symptoms when exposed to allergens: List medication/actions required : Epipen____Benadryl____Inhaler____ If **yes**, please contact school nurse for the Allergy/Bite sting health history form/Emergency Plan
Seizures Date of last seizure_____	yes	no	If **yes,** please contact the school nurse for the Seizure health history form/Emergency Plan
Heart Condition	yes	no	describe
Orthopedic problems	yes	no	describe
Bowel/Bladder problems	yes	no	describe
Neurological problems	yes	no	describe
Hearing deficits	yes	no	Use of assistive equip such as aids?
Vision Deficits	yes	no	glasses____contacts____
Immune Deficiency	yes	no	describe
Other	yes	no	describe

Please list name, dose, time and reason for any daily medications:_____
_____

The School district Medication policy states that your student may receive the following medications (generic form) with signed permission from you, and the nurse determines if the child needs the medication. If you would like your child to receive any of the following medication(s) should the need arise, please check the appropriate box.
My Child may be given:

○Tylenol ○Ibuprofen ○Pepto Bismol ○Rolaids/Tums ○Benadryl

IF A STUDENT NEEDS A MEDICATION FROM HOME, PLEASE FILL OUT THE PERMISSION FORMS AND A DESIGNATED ADULT HAS TO BRING THE MEDICATION TO THE HEALTH OFFICE. IT IS AGAINST SCHOOL POLICY FOR STUDENTS TO CARRY MEDICATION.

I UNDERSTAND THAT AS A PARENT/GUARDIAN, IT IS MY RESPONSIBILITY TO KEEP THE HEALTH OFFICE UPDATED ON MY CHILD'S HEALTH.
I UNDERSTAND THAT THIS HEALTH INFORMATION WILL BE SHARED WITH THE PERSONS LISTED BY PARENT ON THEIR ENROLLMENT FORM AND SCHOOL STAFF AS NEEDED FOR THE HEALTH AND CARE OF MY CHILD

PARENT/GAURDAIN SIGNATURE_____Date_____