Student Health Information

School: Whitwell Elementary School

Student Name Grade Teacher

Birthdate Parents/Guardian’s Name

Contact Phone#

Family Doctor’s Name Phone

Does the student wear glasses or contacts? Have hearing aids

If your child has any of the following check YES ( if answered no, go to bottom of page and sign and date)

 Heart .. Type of Heart Problem

Diagnosed at what age

Name of Regular HeartMedication

Does the student require medication before dental work?

If yes, what is the name of the medication and dosage?

Any restrictions on activites?

Last Doctor visit for heart problem

List signs/symptoms which require emergency action and what actions should be taken

Name of Doctor treating heart problem

Phone Number ( ) -

**\_\_\_\_Diabetes\_\_\_Type I \_\_\_Type II Age of diagnosis\_\_\_\_\_\_\_\_\_**

Insulin @ school : Type of insulin

Pump: Type of insulin

Blood Glucose checks @ school:

Check Ketones @ school: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Glucagon ordered? If so, what is the expriation date?

**Have you provided a container of snacks for school and bus to treat low blood sugar? \_\_\_\_\_\_\_\_This is strongly recommended!**

Name of Doctor treating diabetes

Phone Number ( ) \_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_Seizures/ Epilepsy Age diagnosed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Types of Seizures\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What causes Seizures?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last Seizure \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What happens before and during a seizure?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is any emergency medication ( Diastat) ordered for school use? \_\_\_\_\_\_\_\_\_\_

Expiration Date for Diastat \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Doctor treating seizures \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number ( ) \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I understand this information will be kept at school and a copy will be given to the school nurse. Other school personnel will be given this information on a need to know basis. I authorize the School Nurse to talk with the physician should a question come up regarding this student’s health information.**

**Parent/ Guardian Signature:**

**Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

 Asthma .. Age of diagnosis

What causes Asthma attacks

Name of Regular Asthma Medication

Name of emergency medication ( Inhaler)

Does student need help with inhaler

Will student keep inhaler with them at school

Will student leave inhaler in office

Nebulizer @ home school\_\_\_\_\_\_\_\_\_

Does student have a Peak Flow Meter

Has Doctor completed and Asthma Action Plan for school

Name of Doctor treating Asthma

Phone Number ( )

Expiration Date on Inhaler

**LIST ALLERGIES TO: ( DESCRIBE REACTION)**

FOOD:

MEDICATON:

INSECT:

LATEX:

**Any Severe Allergies? ( Anaphylaxis):**

**YES NO**

List severe allergies and reactions:

Is an Epipen prescribed for school use:

If so, what is the expiration date on Epipen?

Comments:

\_\_\_\_\_\_\_High Blood Pressure ( Age diagnosed\_\_\_\_)

Medication for High Blood Pressure \_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_Migraine Headache

Medication for Migraine \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_ADD \_\_\_\_\_\_\_\_\_ADHD

Medication \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Will this medication be given at school? \_\_\_\_\_\_\_\_\_\_

When was ADD or ADHD diagnosed? \_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_Hemophilia \_\_\_\_Sickle Cell Anemia\_\_\_\_Shunt

Other Health Problems \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

List medications student takes regularly at home

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is it necessary that any medications be taken at school? \_\_\_\_\_\_\_

If so, list the medication \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If medications must be taken during school hours, a medication authorization form (available at school ) must be completed by the parent AND the physician EACH school year.

If this student’s health conditions or medication (s) change during the school year or if you have questions or comments please contact your child’s school.