USD 322 Annual Student Health History Update

Student's Name _______________________________ Date of Birth _______________ Grade/Teacher ______________

Primary Doctor & Location ___________________________________ Specialty Doctor & Location __________________________________

An annual updated health history is a valuable tool that provides current information about the health needs of your student for this school year. This information will be kept in your child's confidential school health record.

Does your child currently have or have a *relevant* medical history of the following: (circle response)

Asthma &/or Breathing Difficulties Yes No Comments: ____

*If yes, do they take medication/inhaler? Yes No Comments: ____

Attention Deficit Disorder Yes No Comments: ____

*If yes, do they take medication? Yes No Comments: ____

Diabetes/Hyper- or Hypo- glycemia Yes No Comments: ____

*If yes, do they take medication? Yes No Comments: ____

Seizures/Neurological Conditions Yes No Comments: ____

*If yes, do they take medication? Yes No Comments: ____

Special Diet &/or Food Allergies Yes No Comments: ____

*If yes, do they take medication? Yes No Comments: ____

Depression/Mental Health Concerns Yes No Comments: ____

Heart Condition Yes No Comments: ____

If any answers regarding medical conditions above are circled "Yes", please contact the school nurse to fill out the proper paperwork needed. An Individualized Healthcare Plan may need to be completed and signed by a licensed medical provider for the general (daily) care of the student. If emergency action is required for the condition, an Emergency Action Plan needs to be completed and signed by a licensed medical provider. These forms will communicate exactly how the medical provider wants the school staff to provide medical care.

If your child needs to take ANY medication during school hours, a medication permission form needs to be completed prior to occurrence. There is a separate form for staff administration under the supervision of the registered nurse, and student self-administration meaning they can possess and self-administer the medication. Forms must be completed AND SIGNED by a licensed medical provider. *It is against school policy for students to have in their possession any medication, prescribed or over the counter, without the proper paperwork filled out completely and signed by a provider.*

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*Please list student's medications

- reminder to complete medication form for any medication, over the counter or prescription, that is to be given during school hours. -

Medication Name	Dosage	Time to be Given	Reason for Medication	Medication form/EAP Completed *(as applicable)* Yes/No

Please continue to back side

RN Reviewed (Initials)

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Please read through segments and circle Yes or No

Screenings – **YES** **NO** **I give/do not give my permission to the school nurse to conduct these screenings.**

Vision and Hearing screenings are conducted in certain grades deemed necessary each year. Oral screenings are conducted as resources are available yearly. If you do not wish for your student to be screened, or to opt out, it is the responsibility of the parent/guardian to provide the school nurse with a copy of the results from the current school year to be placed with the student's health file.

*If you so choose, which screenings are you opting out of ____

Emergencies - **YES** **NO**

I give my permission to the school authorities present during any emergency or accident involving this student, to obtain the services of a physician and/or to transport the student to the nearest hospital for medical treatment. I also give permission to the physician/hospital to treat the student in my absence.

Health Information – **YES** **NO**

Health files are kept confidential; however, I understand and give my permission for the school nurse or administration to determine when appropriate portions of your student's health file may be shared with other school district staff members that are providing services to your student. If further communication is needed between the school nurse and a medical provider, a separate release of information will be completed at that time.

Immunizations - **YES** **NO**

I give consent for the immunization information in my student's health file to be released to the Kansas Immunization Program and other health facilities as needed for the purpose of assessment and reporting. There are a number of diseases that are required to report by law. Any immunization clinics that may be held at the school throughout the school year will require authorization separate from this consent. If you are exempt from immunizations, please speak to the school nurse for further requirements.

During the school year you may be contacted by the school nurse to discuss your student's heath or health plan needs. Please be sure to leave the most up to date contact information for your student's file**. All supplemental health forms will be available on the USD 322 website (www.usd322.org) for use under the school nurse tab.**

By signing below, I affirm that the information given on this registration form is correct to the best of my knowledge, that I understand my responsibilities as a parent/guardian, and that I will notify the school of any new changes in the student's health conditions or medications as they occur.

Parent/Guardian Signature ____ **Date** _________________________

- Office Use Only -

__________	**IEP**	N/A	Complete	Not Complete
		Comments____		
__________	**EAP**	N/A	Complete	Not Complete
		Comments____		
__________	**Medication Forms**	N/A	Complete	Not Complete
		Comments____		
__________	**Other**	Comments ____		
		____		

RN Reviewed (Initials)

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