**RIVER VALLEY COMMUNITY SCHOOL**

**CONFIDENTIAL STUDENT HEALTH INFORMATION FORM**

NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_BIRTHDATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_GRADE\_\_\_\_\_\_\_

ALLERGIES\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FAMILY DOCTOR\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_FAMILY DENTIST\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TYPE OF HEALTH INSURANCE: Private \_\_\_\_\_Hawk-I\_\_\_\_\_Title 19/Medicaid\_\_\_\_\_No Insurance\_\_\_\_\_

IS YOUR CHILD COVERED BY ANY TYPE OF DENTAL INSURANCE? YES \_\_\_\_\_ NO \_\_\_\_\_

**HEALTH CONCERNS:** Mark the box if your child has a history of the following conditions.

□ Asthma or Reactive Airway Disease Triggers\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Will an inhaler be needed at school? Yes \_\_\_\_\_\_\_ No \_\_\_\_\_

Will the student carry their own inhaler? Yes \_\_\_\_\_  No \_\_\_\_\_

□ Diabetes Does the student use insulin? Yes \_\_\_\_\_\_\_ No \_\_\_\_\_ Does the student have glucagon? Yes \_\_\_\_\_\_\_ No \_\_\_\_\_

□ Seizure Disorder Does the student have rescue medications? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Allergies (Food, Insect, Seasonal, Medication) Yes \_\_\_\_\_\_\_ No \_\_\_\_\_

List: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Does the student have an EpiPen? \_\_\_\_\_\_\_

Will the student need a lunch accommodation? Yes \_\_\_\_\_\_\_ No \_\_\_\_\_

Any Other Health concerns? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any Recent Surgeries or Hospitalizations? Yes \_\_\_\_\_\_\_ No \_\_\_\_\_ If Yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any Recent Serious Injuries or Accidents? Yes \_\_\_\_\_\_\_ No \_\_\_\_\_ If Yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MEDICATIONS (Please list name, dose, time taken and reason for use)

**PERMISSION FOR ADMINISTRATION OF OVER THE COUNTER MEDICATION AT SCHOOL**

\_\_\_\_\_**I give permission** to the school to administer over-the-counter medications (such as but not limited to acetaminophen, ibuprofen, antibiotic ointment or cough drops) to my child if supply is available. Medication will be given per label indication and dosed according to age.

\_\_\_\_\_**I do not** want my child to receive medication at school.

**PERMISSION TO SHARE HEALTH INFORMATION**

At certain times it may be necessary and important to share your child’s health information with school staff and/or your healthcare providers. This is done strictly on a need-to-know basis only.

\_\_\_\_\_ **I give permission** to share Health Information with school staff and my doctor/dentist.

\_\_\_\_\_ **I do not** give permission to share my child’s health information.

Parent/Guardian Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health Conditions:**

Asthma or Reactive Airway Disease:

* Asthma Action Plan required
* Medication Authorization Form for Inhaler/Nebulizer (if medication stored in nurse’s office)
* Self-Administration Consent Form (if student will self-carry inhaler)

Diabetes:

* Diabetic Medical Management Plan required
* Prescription Drug Authorization Form required (if medication is needed at school)

Seizures:

* Seizure Action Plan required
* Prescription Drug Authorization Form (rescue medications needed at school)

Allergies:

* Allergy & Anaphylaxis Emergency Plan required
* Diet Modification Form
* Self-Carry/Self Administration of Non-Asthma Related Medication (if carrying an Epi-Pen)
* Prescription Drug Authorization Form (if medication stored in nurse’s office)

A **Prescription Drug Authorization Form/Medication Administration Form** is used if your student needs to take medication here at school, either a prescribed medication for a long term diagnosis (including allergies and asthma) or a short term medication for an acute illness.  Any prescription medication must be transported to school in the pharmacy bottle with the correct label attached and any over-the-counter medication needs to be in its original container**.**

* Medicine will be administered by the school nurse or a staff member who has successfully completed a medication administration course.

**Emergency Contacts:** It is crucial that the school has the most up-to-date contact phone numbers in case we need to contact you for an emergency or illness. If your work or cell phone number changes, please contact the school office.

**Communicable Diseases:** If your child is staying home due to: chicken pox, impetigo, strep throat, fifths disease, ring worm, pink eye, influenza, etc., notify the school of this diagnosis when calling the school to report your child is sick. The nurse may need to send home a note to his/her classmates to inform them of their potential risk. Your child’s identity will be kept confidential and no identifying information is given out.

**When to keep your child home** **from school:** Please keep the health of others in mind when deciding on whether to keep your child home or send them to school. If they have symptoms of COVID19, have vomited or had diarrhea within the past 24 hours, have a fever of 100.0or higher, have an undiagnosed rash, or sore throat please do not send them to school. Call the school to report their absence. They should be fever free for 24 hours without the help of fever-reducing medication or have taken a prescribed antibiotic for at least 24 hours before returning to school.

**Any** **Illness or Injury** that results in the need for the child to sit out of physical education class will require a signed note from a physician if it is for longer than 2 days. If the student is sitting out of PE they will also sit out of recess, if applicable.

*Thank you for your participation in making our school a healthy place for all students. If you have any questions or concerns, please contact Lori Baldwin, School Nurse (712-447-6318 Ext 2253).*

Forms are available on our website: <https://www.rvwolverines.org>