Slate Valley Unified School District

Annual and Initial Enrollment Health Information and Consent for the School Nurse, page 1

School: OVS _____ BVS _____ CES _____ CVS _____ FHGS _____ FHUHS _____

STUDENT'S NAME: ______________________________ DOB: _________ Age: ____GRADE:_______

Medical History/Update:

Child's Doctor ___________________________ Town/city: _______________ phone # _____________Date of last Physical ___________

Child's Dentist ___________________________ Town/city: _______________ phone # _____________ Date of last cleaning ___________

Child's Specialist__________________________ phone#_____________ Reason______________________ Date of last visit: ___________

Does your child have Health Insurance? Yes ____ No____ Name of Insurance ____

Does your child have Dental Insurance? Yes ____ No____ Name of Insurance ____

Would you like information on obtaining health insurance mailed to you? Yes ____ No____

Would you like information on obtaining dental insurance mailed to you? Yes ____ No____

Does your child have: (please circle and write any details that would help the nurse in caring for your child physically, socially and emotionally):

YES/NO **Allergies:**_______________________________ (medications, bees, environmental, foods)

YES/NO Has your child been prescribed an EpiPen? ______ Benadryl? _______ Please send in physician orders.

YES/NO Diabetes ____

If yes, please send in medication orders and treatment plan from their doctor-list medications below.

YES/NO Has a doctor, nurse or other health professional EVER said that your child has asthma?

YES/NO IF Yes, Does your child still have asthma?

If yes, please send in a current Asthma Action Plan from their doctor

YES/NO Need an inhaler at school-this includes field trips? List below on medication section

YES/NO Need an inhaler prior to gym or sports?-be sure this is correct on their sports physical form

YES/NO Have a seizure disorder?

If yes, please send in a Seizure Action Plan from their doctor

YES/NO Have an emergency medication for seizures-please list below

YES/NO Have a heart condition/disease: ____________________________ Any treatment? _____________________________________

YES/NO Do they need antibiotics prior to dental work?

YES/NO Does your child have any cavities or in need of any dental care?

YES/NO Have a mental health diagnosis: ___________________________ Medication: ____

YES/NO Do they receive counseling outside of school?

YES/NO See a school counselor regularly?

YES/NO Have ADD/ADHD?

YES/NO If yes, do they take medication for it: __________________________________

YES/NO Ever had a concussion Age(s): ____________________ If Yes, have they ever had a hard time recovering from one? ________

YES/NO Have frequent stomachaches or digestive disorders/diseases? _________________________ treatment: _____________________

YES/NO Have any vision impairment?

YES/NO If Yes, Do they wear contact lenses or glasses?

YES/NO Have any hearing impairment?

YES/NO If Yes, Do they wear hearing aids?

YES/NO Does your child require any treatments at school?

Please list: ____

YES/NO IS your child on an education plan (EST, 504, IEP)? Circle one Reason or diagnosis: _____________________________________

YES/NO Does your child have a doctor's order limiting PE class or sports?

YES/NO Does your child have any other diagnosis that impacts school participation or attendance?

YES/NO **Has your child been diagnosed with COVID -19? IF so, when? ________________________________**

YES/NO **Has anyone in your household been diagnosed with COVID-19? IF so, when? ___________________________**

PLEASE LIST ALL MEDICATIONS YOUR CHILD TAKES: Send in **physician signed** prescription form for those to be given at school-please include prescription forms for inhalers, EpiPens, Anti-Seizure, Glucagon, etc.

Med Name________________________ strength/mg:__________ # of tabs/puffs_____ time taken_______

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Med Name________________________ strength/mg:__________ # of tabs/puffs_____ time taken_______

Med Name________________________ strength/mg:__________ # of tabs/puffs_____ time taken_______ **TURN**

Med Name________________________ strength/mg:__________ # of tabs/puffs_____ time taken_______ **OVER**

STUDENT'S NAME: ____ DOB: __________ GRADE: _____

The following are non-prescription medications that are available from the school nurse. Please check the medications that you approve to be given to your child by the school nurse/designee.

_____Ibuprofen (Advil)-for headaches, body aches, pain
_____Acetaminophen (Tylenol)-for headaches, body aches, pain
_____Bacitracin Ointment or triple antibiotic ointment
_____Cough Drops-for coughs or sore throats
_____Antacid Tabs/liquid-for stomach upset/mouth discomfort
_____Nasal Decongestant for sinus pressure/stuffy nose (high school only)
_____Hydrocortisone Cream-for rashes, insect bites, skin irritants
_____Chloroseptic Spray-for sore throats
_____Diphenhydramine (Benadryl)-for allergic responses
_____Claritin-for environmental allergies
_____Saline Eye Solution-for eye irritants, rinsing contact lenses
_____OraGel-for mouth sores, mouth pain
_____Callergy Clear for burns, insect bites, skin irritants or abrasions
_____Calamine for poison plant reactions
_____Imodium AD for diarrhea (high school only)
_____Sunscreen
_____Splinter Removal-use of needle and tweezers

Any other over the counter medicines will need to be provided by you along with written instructions and in original packaging.

According to the American Academy of Pediatrics physicals should be done on children every year. Please send in the most recent copy of their physical. For grades 5 and up-What sport(s) will your child be participating in this year _____________________ _________________________ To participate, a student must have a physical **every year**. *If you are unsure of the date of your child's last physical, please check with the AD or school nurse for the most recent one the school has on file. For information regarding the Bright Futures guidelines for Preventive Pediatric Health, go to their website: https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf

I consent for the nurse or the nurse's designee to treat my child. I authorize the doctor and dentist above to communicate with the nurse and tooth tutor regarding physicals, immunizations, visits related to illness or injury affecting school and dental care. In an emergency, I authorize school personnel to seek emergency medical or dental care, including transportation via ambulance to the emergency room at my expense. I request the school to contact me, or one of my designated contacts, as listed on the school registration form, as soon as possible following emergency treatment. I authorize the physician in charge to administer whatever emergency treatment is necessary at my expense.

Below is my contact information:

Legal Parent/Guardians (to contact first during school hours):

Name: __________________________ Relation to student:_____________ Phone:_____________ Work Phone:_____________

Name: __________________________ Relation to student:_____________ Phone:_____________ Work Phone:_____________

People you authorize to pick up your child from school after speaking with parent/guardian:

Name: __________________________ Relation to student:_____________ Phone:_____________ Work Phone:_____________

Name: __________________________ Relation to student:_____________ Phone:_____________ Work Phone:_____________

Can your child walk home? __________ Can your child drive home? ____________

Parent/Guardian Signature: ____ Date: ___________

Signature of Student (if 18 or older): ___________________________________ Date: ___________