School Year: **2023-2024**

Houma Christian School

HEALTH INFORMATION

Part 1 STUDENT DEMOGRAPHIC AND CONTACT INFORMATION					
Student Name: Last First M.I.		Sex: ☐M ☐F	DOB:	Grade:	Teacher:
Allergies:		Weight:	Height:		
Student's Address:		City:	State:	Zip:	
Name of Mother/Legal Guardian:	Home Phone	Work Phone	Cell Phone		Employer
Name of Father/Legal Guardian:	Home Phone	Work Phone	Cell Phone		Employer
Emergency contact other than parent/guardian	Home Phone	Work Phone	Cell Phone		Employer
Name of Peciatrician/Primary Care Provider	Phone Number	Other Specialist		Phone Number	

My child has a medical, mental or behavioral condition that may affect his or her school day: ☐ Yes ☐ No

Please describe condition: _____

_____

_____

_____

In order to make sure my child's special health needs are met, I allow my child's information to be shared confidentially with physicians, physician's office staff, and professional and lay school staff as determined by the school principal and/or school nurse. I will notify the school/school nurse of any changes in my child's health or medical condition(s).

Parent/Legal Guardian Signature: _____ Date: _____

Part 2 COMPLETE MEDICAL INFORMATION

☐ ALLERGIES

Allergy Type: ☐ Food (list foods)_____ ☐ Drug/Medication_____

☐ Insect sting (list insects) _____ ☐ Other_____

Describe reactions: _____

Date of last occurrence_____

Indicate currently prescribed medications and/or treatments: ☐ Oral antihistamine ☐ epinephrine ☐ Other

☐ ASTHMA ☐ Mild ☐ Moderate ☐ Severe

List triggers (i.e. tobacco, dust, pets, exercise, etc.) _____

Student's symptoms ☐Chest tightness, discomfort, pain ☐ Difficulty ☐ Breathing ☐Coughing ☐Wheezing

☐ Other_____

Currently prescribed medications and treatments: _____

Date of last hospitalization due to asthma: _____ Date of last Emergency Room visit due to asthma _____

Does the student have a written asthma management plan? ☐ Yes ☐ No Is peak flow monitoring used? ☐ Yes ☐ No

☐ **DIABETES** Type: _____

Currently prescribed medications and treatments: ☐ Insulin: ☐ syringe ☐ pen ☐ pump ☐ Glucagon

☐Oral Medication(s) List Medications _____

☐ Blood Sugar Testing ☐ Continuous Glucose Monitor

Is special scheduling of lunch or Physical Education required? ☐ No ☐ Yes: _____

☐ **SEIZURE DISORDER**

Type of seizure ☐ Absence ☐ Generalized Tonic-Clonic (Grand Mal/Convulsive)

☐ Complex Partial ☐ Other (explain)_____

Physical Education restrictions: ☐ No ☐ Yes (explain) _____

Medications: ☐ No ☐ Yes: List Medications: _____

Date of last seizure: _____ Length of seizure: _____

☐ **OTHER HEALTH CONDITION**

☐ Anemia	☐Depression	☐Hemophilia	☐Speech Problems
☐ ADD/ADHD	☐ Digestive disorders	☐ Heart Conditions	☐Other (explain)_____
☐ Cancer	☐ Emotional/Psychological	☐ Physical Disability	_____
☐ Cerebral Palsy	☐ Juvenile Rheumatoid Arthritis	☐ Sickle cell disease	_____
☐ Cystic Fibrosis	☐ Skin disorders	☐ History of Chicken Pox	_____

Physical Education restrictions: ☐ No □ Yes (explain) _____

Are there home medications for conditions listed above? ☐ No ☐Yes List medications: _____

_____

Restrictions/accommodations for conditions listed above: ☐ No ☐ Yes Explain: _____

_____

Special diet required? ☐ No ☐ Yes Explain: _____

Special procedures required (i.e., urinary catheterization, oxygen, gastrostomy or tracheostomy care, suctioning)? ☐No

☐Yes Explain: _____

_____

Are there anticipated frequent absences or hospitalizations expected? ☐No ☐ Yes (explain) _____

_____

☐ **VISION CONDITIONS**

☐ Contacts/Glasses ☐ Other: _____

☐ **HEARING CONDITIONS**

☐Hearing aids ☐ Other _____

Special Safety considerations required: ☐No ☐ Yes (explain) _____

_____

Special assistance with Activities of daily living required? Yes No (explain) _____

(i.e. eating, toileting, walking)

_____ _____

Parent Signature Date