HEALTH INFORMATION

TO BE COMPLETED BY PARENT OR GUARDIAN EACH SCHOOL YEAR

PART 1 Parent Or Guardian To Complete. Parent or guardian is encouraged to participate in the development of an Individual Health Care Plan if needed.

Student Name Last	First	Middle	Sex ☐ M ☐ F	DOB

School Year	Grade	Teacher Name

Home Phone	Father Work Phone	Mother Work Phone

My child has a medical condition that may affect his or her school day ☐ NO ☐ YES (please complete Part 2)

Parent or Guardian Name (Print or Type)

Parent or Guardian Signature Date

PART 2 Complete All Boxes That Apply To Your Child. Parent or guardian is responsible for providing the school with any medication, special food, or equipment that the student will require during the school day. Check with the school health room to obtain correct medication and procedural forms. If an individual school health care plan is indicated, parent or guardian is responsible for providing the school public health nurse with necessary medical information, appropriate authorization forms, and written consent to exchange information with the child's physician.

☐ ALLERGIES

Allergy Type

☐ Food List food(s) _____

☐ Medication List medicine(s) _____

☐ Bee sting _____

☐ Other (list) _____

Reactions Type ☐ Mild ☐ Severe Date of last severe reaction _____

☐ Coughing ☐ Hives ☐ Rash

☐ Difficulty breathing ☐ Local swelling ☐ Wheezing

☐ Generalized swelling ☐ Nausea ☐ Other _____

Currently prescribed medications and treatments

☐ Oral antihistamine (Benadryl, etc.) ☐ Epinephrine ☐ Other _____

☐ FOOD INTOLERANCE

☐ Due to Gastrointestinal (Digestive) distress List Foods _____

☐ Due to Religious preferences List Foods _____

☐ ASTHMA

Triggers ☐ Exercise ☐ Environmental ☐ Other (list) _____

Symptoms

☐ Chest tightness, discomfort, or pain ☐ Difficulty breathing ☐ Throat itch, tightness, or soreness

☐ Coughing ☐ Hoarseness ☐ Wheezing

☐ Other _____

Currently prescribed medications and treatments

☐ Inhalers ☐ Oral antihistamines ☐ Oral steroids

☐ Nebulizer ☐ Oral bronchodilator ☐ Peak flow monitoring

Date of last hospitalization related to asthma _____

CONTINUE ON REVERSE

☐ Diabetes

Currently prescribed medications and treatments

☐ Insulin ☐ Syringe ☐ Pen ☐ Pump

☐ Blood sugar testing ☐ Carbohydrate Counting

☐ Glucagon

☐ Oral medication(s) List medication(s) _____

Date of last hospitalization related to Diabetes _____

Is special scheduling of lunch or Physical Education required? ☐ NO ☐ YES

☐ Seizure Disorder

Type of seizure

☐ Absence (staring, unresponsive) ☐ Complex partial ☐ Generalized tonic-clonic (grand mal, convulsive)

☐ Other (explain) _____

Physical education restrictions ☐ NO ☐ YES

Medications needed *IN SCHOOL* ☐ NO ☐ YES List medication(s) _____

Date of last seizure _____ Length of seizure _____

Currently prescribed medications _____

☐ Other Health Conditions

☐ Cancer ☐ Heart condition (be specific) _____

☐ Hemophilia ☐ Sickle cell anemia ☐ Physical disability (be specific) _____

☐ Gastrointestinal Condition (be specific) _____

Other (explain) _____

Medication needed *IN SCHOOL* ☐ NO ☐ YES List medication(s) _____

Special procedures (e.g. catheterization, cardiac monitor, etc.) required *IN SCHOOL* ☐ NO ☐ YES

(explain) _____

☐ Vision Conditions

☐ Contacts ☐ Glasses ☐ Non Correctable

☐ Other _____

☐ Hearing Conditions

☐ Hearing aid(s) ☐ Non Correctable

☐ Other _____

☐ Physical Restrictions

Does your child's health condition restrict participation in Physical Education? ☐ NO ☐ YES

PARENTAL AUTHORIZATION TO ADMINISTER MEDICINE

I am the parent with legal custody or the legal guardian of _____, a student attending Pioneer Jr. - Sr. High School. This student requires medication at intervals during the school day.

I hereby give my consent and authorize the school nurse, the school principal or school personnel of the Pioneer – Pleasant Vale School to:

____ Administer _____, a non-prescription medication when needed.
(Tylenol, Ibuprofen, etc)

____ Administer _____, a filled prescription medication which I am hereby supplying you, in accordance with the directions for the administration of the medicine listed on the label of the vial.

____ Administer _____, a filled prescription medication which I am hereby supplying you, in accordance with the written instructions of the physician prescribing the medicine, which is attached hereto.

I understand that under state law the Board of Education, the Pioneer-Pleasant Vale School District, or employees of the Pioneer-Pleasant Vale School District shall not be liable to the student or the student's parent or guardian for civil damages for any personal injuries to the student which result from acts or omissions of school employees in administering the medicine I have hereby authorized.

Dated this _____day of _____,_____.

_____
(Parent with Legal Custody or Guardian)

_____
(Address)

WITNESS:

_____