**RETURN TO THE SCHOOL NURSE** School Year 20___ to 20___

Student Health Information

Student Name: ______________________ DOB: __________ Teacher/Grade ____________

Parent/Guardian: ______________________ H)__________ C) __________ W) __________

Parent/Guardian/Emergency Contact: ________________ H) ________ C) ________ W) ________

Physician's Name: __________________ Phone #: __________ Hospital Preference: __________

Does your child have any of the following health issues?

Allergies: Yes No If Yes, allergic to what? ______________________________

List symptoms of allergy: ______________________________

Is medication(s) required at school, list ______________________________

Asthma: Yes No If Yes, when was the last attack? ______________________________

Is medication(s) required at school, list ______________________________

What causes the attack? ______________________________

Seizures: Yes No If Yes, date of last seizure: ______________________________

If Yes, what type of seizures: ______________________________

Is medication(s) required at school? ______________________________

Diabetes: Yes No If Yes, name of insulin/medication(s): ______________________________

Heart Problems: Yes No Is exercise limited: Yes No Taking Medication(s): Yes No

Type of problem: ______________________ List medication(s) ______________

Does your child have: Hearing Loss: Yes No Hearing Aids: Yes No Glasses: Yes No Contacts: Yes No

Other Health Issues: Yes No List ______________________________

Does your child need to take other medication(s) at school: Yes No What/Why? ______________

**<u>**All medication(s) administered at school MUST be authorized by the child's physician!!**</u>**

Parent(s) **MUST** provide all medication(s) to be given at school. Request Medication Form from school staff.

List signs and symptoms regarding your child's illness you have listed above.

1. ______________________________
2. ______________________________
3. ______________________________

Actions to be taken.

1. ______________________________
2. ______________________________
3. ______________________________

I agree that this is my child's Individual Health Plan (IHP) regarding the above medical condition(s).

Parent/Guardian Signature: ______________________________ Date: ______________

School Nurse's Signature: ______________________________ Date: ______________