# EAST UNION COMMUNITY SCHOOLS

**Health Related Services**
**Annual Health Information**
**K-12**

**Student Names**_____ **Birth Date**_____ **Sex**_____

**Grade/Room**_____ **School attended last year**_____

## HEALTH CONCERNS

Please put an ( X ) if your child has any of these health concerns:

_____ No health concerns
_____ADHD/ADD
_____Allergies (to what?)_____
_____Asthma or other breathing problems
a. Has your child ever been diagnosed by a doctor as having asthma? ____Yes____No
b. Has your child had episode(s) of wheezing (whistling in the chest) in the last 12 months? ____Yes____No
c. In the last 12 months have you heard your child wheeze or cough after active playing? ____Yes____No
d. Other breathing problem (describe)_____
_____Bladder problems/Bowel problems (describe)_____
_____Chickenpox (list month and year he/she had disease)_____
_____Diabetes: ____Type 1 ____Type2 Managed by: ____Diet only ____Oral Meds
____Insulin Injections ____Insulin pump
_____Heart Problems (describe)_____
_____Seizures: Type (describe)_____
_____Social/emotional/behavioral/mental health concerns (describe)_____
_____Other health concern of significant history of problems (describe)_____
_____Activity restrictions: (describe)_____
Any surgeries or hospitalizations? _____Yes____No If yes, explain_____
_____

**EMERGENCIES:** Does your child have a health problem that could result in an emergency? ___Yes___No
If yes, describe:_____

**MEDICATIONS:** List **ALL** medications that your child takes every day or when needed. A consent is **REQUIRED** for **ALL** medications taken at school. **A new consent is needed each school year.**
Forms are available in the health office.

| Medication Name | Purpose | Dose | How often taken? |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**VISION**

____No vision problems
____Glasses/contacts prescribed
____Wears glasses/contacts all of the time
____Wears glasses in classroom only
____Glasses lost/broken
____Has (or has had) glasses but does not wear
____Other (describe)_____

**HEARING**

____No hearing problem
____Frequent ear infections (more than 3 per year)
____Has ear tube(s) Date inserted_____
____Hearing loss ____right ear ____left ear
____Hearing aid(s) ____right ear ____left ear
____Aids lost/broken
____Has (or has had) aids but does not wear
____Other (describe)_____

**DENTAL**

____By checking this, I give permission for the **I-Smile** program to provide a dental screening, @ NO CHARGE, if needed, by a registered dental hygienist. This oral screening does not take the place of your child's regular visit to the dentist, but it does satisfy the Iowa school mandate audit.

**HEALTH INSURANCE**

____My child has health insurance: If yes, what kind_____
____My child has no health insurance

**HEALTH CARE PROVIDERS**:

Does your child have a doctor or clinic where they usually go for health care? ____Yes____No
If there is no family physician, will the choice made by the school be satisfactory? ____Yes____No
Hospital preference:_____

| Name of Doctor or Clinic | Location and Phone | Approximate date of Last Exam |
|---|---|---|
| Primary Health Provider (regular doctor) | | |
| Eye Specialist | | |
| Ear Specialist | | |
| Dentist | | |
| Other Specialist (specify type) | | |

**Comments:**

This health information may be shared with East Union school staff as needed. If you do not want this health information shared, please contact the school nurse.

Parent/Guardian Signature:_____ Daytime Phone_____
Print Parent/Guardian name;_____ Date:_____