District 49

HEALTH INFORMATION

Must be updated annually

Forward this page to the Health Room

'Confidential information will be shared with school staff on a need to know basis'

Student Name: _____ Grade: _____ School: _____

Date of birth: _____ Teacher (***Elementary only***): _____

Does your child currently have any of the following health concerns? (Please circle conditions)

Dr. Diagnosed ADD/ADHD Medication: _____	Dr. Diagnosed AUTISM SPECTRUM	Dr. Diagnosed Heart Condition Activity Restriction **Yes/No**	Dr. Diagnosed Emotional Condition Diagnosis: _____
Dr. Diagnosed ASTHMA Medication: _____	Dr. Diagnosed Diabetes: Type: _____	Other Allergy (medication/environmental/ other): _____	Dr. Diagnosed Migraine Headaches:
Seizure Disorder/Epilepsy Type of Seizure: _____	Dr. Diagnosed Chronic Bowel/Bladder Issues	Audiologist Diagnosed Hearing Loss	History of Head Injury/Dr. Diagnosed Concussion: Date of injury: _____

Please describe conditions listed above in ***greater*** detail: _____

List any **other** current medical concerns which may impact your student's access/learning at school (***include dietary/food restrictions/physical restrictions):*** _____

Recent Hospitalizations (***within the past year***): Date of hospitalization: _____

Medication/Dose/Time Taken:_____(at home _____, at school_____, both_____)

****Use reverse side of this sheet for more space to list medications if needed**

Does your child have any ***significant life threatening allergies*** that you feel school personnel need to know about? Yes/No;
If yes, list the specific allergy and reaction/symptoms your student has experienced: _____

Required Parent Information: (circle one) **I WILL** or **I WILL NOT**
be providing rescue medication such as Epinephrine for severe allergy noted above. If rescue medication is NOT provided, I understand EMS/911 will be called if an emergency arises and agree to emergency care permission listed below:

Does your student wear glasses/contacts? ***Yes/No*** Vision Diagnosis: _____

Date of last vision exam through your student's eye doctor/eye specialist:_____

Does your child have Medicaid? ***Yes / No *If your child is NOT covered by health insurance, please call Falcon Peak Health Center: 719-344-6247 for more information.***

Emergency Care Parent Permission: In case of serious illness or injury, first aid will be rendered in accordance with local school policies. If ambulance service is necessary, parent must assume financial responsibility. If parent/guardian cannot be reached in the event of such emergency, please send my student to: _____ (hospital) or nearest medical facility. **Parent/guardian signature:** _____

I, _____ (parent/guardian) give school health office permission to contact my student's doctor to obtain immunization records (parent/guardian signature): _____

Physician's Name: _____ **Phone number:** _____

Form Completed by:_____ **Relationship to Child:** _____**Date:** _____

Revised January 2018