RUSH COUNTY SCHOOLS

Health Form

2012-13 School Year

Student Last Name_____ First Name_____ Middle Name_____

School_____ Grade for 12-13_____ Date of Birth_____

Check the following <u>diseases</u> this child has had and give approximate dates.

Chickenpox	_____	_____	Rheumatic Fever	_____	_____	Allergies	_____ _____
Mononucleosis	_____	_____	Scarlet Fever	_____	_____	Others	_____
Pneumonia	_____	_____	Whooping Cough	_____	_____		_____

Does this child wear glasses/contacts? _____ Yes _____ No

Health Information

Name of family doctor_____ Approximate date of child's last physical examination_____

Comments or recommendations made by examiner at that time_____

Present condition of child's health_____

Had child ever been examined or treated by other medical specialists? _____ Yes _____ No
If yes, please explain_____

Please check if child has experienced problems with any of the following:

_____ Allergies _____ Excessive Crying _____ Tiredness _____ Dizzy Spells
_____ Eating _____ Physical Growth _____ Eye Strain _____ High Temperatures
_____ Headaches _____ Loss of Consciousness _____ Nervousness _____ Other

Comments_____

What has the examiner reported to parents regarding the above?_____

Has the child ever had an illness, accident, or emotional experience which seems to delay social, emotional or physical growth?
_____ Yes _____ No If yes, please explain._____

Have there been any circumstances in the child's life that you believe were hard for the child and that you think would help us understand any problems the child might have?_____

Current Medications

Does the student take any medications (prescribed and/or OTC)? _____ Yes _____No

Explain, including dosage, and frequency._____

Is medication required during school hours? _____ Yes _____ No ***(If yes, please obtain necessary form at registration of from nurse.)***

Student Health Status

Complete the following checklist by indicating any of the following conditions, past or present. Continue of back if more space is needed.

	Yes	No		Yes	No
Heart Problem/Defect			Hearing Deficit		
ADD/ADHD			Hepatitis		
Anemia (include Sickle Cell)			Surgery		
Arthritis			Activity Restriction		
Back/Neck Injury or condition			Physical Disability		
Blood/Clotting Disorder			Mononucleosis		
Cancer/Leukemia			Epilepsy		
Diet Restrictions			Vision Deficit		
Head Injury/Concussion			High Blood Pressure		
Headaches			Other		

Please give details for all that are marked **<u>Yes</u>** above._____

Does your child have asthma? _____ Yes _____ No If yes, _____ Mild _____ Moderate _____Severe

Does your child have allergies? _____ Yes _____ No If yes, nature of allergy_____
If yes, __ Mild _____ Moderate _____Life-threatening Epipen prescribed _____ Yes _____ No

Does your child have diabetes? _____ Yes _____ No
If yes, insulin, glucometer, pump, and care needed at school_____

Does your child have seizures? _____ Yes _____ No If yes, describe type and meds taken_____

_____

Schools previously attended_____

_____

Consents and Signature
The School Nurse has permission to contact my child's doctor if medically necessary. _____ Yes _____ No

_____I understand that in order to provide the safest possible environment and most complete educational program for my child, the school needs to be informed of any health or medical conditions that may affect my child's school day or impact his/her learning.

_____I understand that medications of any kind are not allowed on school grounds without the proper medical authorization on file. I understand that school staff, including the nurse MAY NOT administer or assist with any medications without the proper medical authorization on file.

_____I understand that for the safety of my child, or to provide for their educational program, the school nurse may need to share information about my child's condition with appropriate school staff. This will be done in a confidential manner. If I do not wish that information shared, I must request this in writing and file it with the school nurse.

Parent Signature_____ Date_____