

# HEALTH INFORMATION:

STUDENT NAME \_\_\_\_\_ DOB: \_\_\_\_\_ GRADE: \_\_\_\_\_  
2011-2012

Does your child have any of the following?

**Yes**    **No**

- Allergies to:** Food: \_\_\_\_\_ Medication: \_\_\_\_\_ Other: \_\_\_\_\_  
Medications: \_\_\_\_\_  
Epi-Pen at school \_\_\_\_ Yes \_\_\_\_ No    Kept in health room/office OR student carries (circle)
- Asthma:** Medications: \_\_\_\_\_  
Inhaler at school \_\_\_\_ Yes \_\_\_\_ No    Kept in health room/office OR student carries (circle)  
\*\*Student may carry inhaler in school provided signed physician/parent consent is on file in school
- Diabetes:** \_\_\_\_ glucometer \_\_\_\_ insulin    Kept in health room/office OR student carries (circle)  
Glucagon at school \_\_\_\_ Yes \_\_\_\_ No    Kept in health room/office OR student carries (circle)
- Heart problems or bleeding disorder** (circle) Medications: \_\_\_\_\_  
Precautions or restrictions: \_\_\_\_\_
- High or low blood pressure**
- Seizures or Epilepsy:** Type of Seizures: \_\_\_\_\_  
Medications: \_\_\_\_\_
- Hearing Loss** \_\_\_\_ hearing aids \_\_\_\_ special seating    Other: \_\_\_\_\_
- Vision** \_\_\_\_ glasses \_\_\_\_ contacts \_\_\_\_ special seating    Other: \_\_\_\_\_
- Serious illness, accident or surgery during the PAST YEAR that may affect school performance  
Specify: \_\_\_\_\_

**Any other health concerns:** \_\_\_\_\_  
\_\_\_\_\_

**Physical Education restrictions (require a doctor's order):** \_\_\_\_\_

**Immunizations received since last school year:**

<u>Immunization</u>	<u>Date</u>	<u>Immunization</u>	<u>Date</u>	<u>Immunization</u>	<u>Date</u>
_____	_____	_____	_____	_____	_____

**\*\*List medications to be taken at school:**

Medication \_\_\_\_\_ Reason: \_\_\_\_\_  
Medication \_\_\_\_\_ Reason: \_\_\_\_\_

**List medications being taken at home:**

Medication \_\_\_\_\_ Reason: \_\_\_\_\_  
Medication \_\_\_\_\_ Reason: \_\_\_\_\_

## **MEDICATIONS \*\***

Medications cannot be taken/administered at school without the appropriate consent forms on file. Please contact the school office to obtain the necessary forms or you may print one from the district website at [www.plymouth.k12.wi.us](http://www.plymouth.k12.wi.us) under school nurse/health info. It is called the "Medication Authorization form."

## **CONFIDENTIALITY**

Every effort to preserve the confidentiality of student health information will be made by those individuals who have access.

## **NOTIFYING STAFF OF HEALTH ISSUES**

While every attempt is made to inform appropriate school personnel of significant health concerns, it remains the primary responsibility of the parent/guardians to inform teachers, coaches, etc. of these concerns.

If you have health-related questions regarding your child, please contact the District School Nurses, Mary Peschke, RN, BSN, NCSN at 920-892-2621 or Tina Roelse, RN, BSN at 920-892-4353.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date