Cheyenne County School District Re-5 Student Health History Form

Required Yearly / Must Sign Below and Date

School Year: _____

STUDENT: _____ Grade: _____ Date of Birth: _____

Immunizations this last year: _____ Date: _____ (**Provide Documentation)**

Any Changes Since Last Year? No _____ Yes _____ (If YES or NEW STUDENT, Please Complete)

Does the student have HEALTH CONCERNS involving:	YES	NO	MEDICATION (Name, Dosage)	NECESSARY MONITORING IN SCHOOL	COMMENTS OR DISCRIBE CONDITION
ASTHMA/RESPIRATORY				EQUIPMENT:	
SEVERE ALLERGIES				FOOD: LATEX: INSECTS: NUTS/PEANUTS:	Is it life threatening? Type of reaction: Date of last reaction:
DIABETES				EQUIPMENT:	
HEAD INJURY					
SEIZURES/ NEUROLOGICAL MIGRAINES					Time & Date of last episode:
HEART/BLOOD					
MUSCLES/BONES JOINTS/SKIN					
BLADDER/KIDNEY					
STOMACH/INTESTINES BOWEL PROBLEMS					
IMMUNE PROBLEMS					
HEARING CONCERNS				Hearing aides? Preferential seating?	
VISION CONCERNS				Glasses or contacts? Reading only?	Color blind? Last eye exam?
GROWTH & NUTRITIONAL CONCERNS					Height: Weight:
DEVELOPMENTAL CONCERNS					
EMOTIONAL/ BEHAVIORAL					
OTHER HEALTH CONCERNS					

Routine or daily medications, treatments or therapies (not listed above): Use back side if necessary or a Specialized Health Care Plan.

Activity restrictions in the school?

Special medical equipment required in school? (E.g. oxygen, wheelchair, etc.)

Have there been any significant changes in your child's health over the last year? Explain:

ILLNESSES, HOSPITALIZATIONS, ACCIDENT/INJURIES and dates: (use other side if necessary)

Health Care Provider(s) Name:_____ Phone Number: _____

To the Parent/Guardian: This information will be shared only with those individuals in the school setting who have a legitimate need to know based on your child's educational and safety needs.

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PARENT/GUARDIAN SIGNATURE: _____ DATE _____

HOME PHONE: _____ CELL PHONE:_____ WORK PHONE: _____

Please contact Tracie Ball, School Nurse, directly @ phone: 719-767-5656 if you would like to discuss any of the above information that you feel is confidential.

HEALTH CONDITIONS OR SPECIAL CONCERNS BASIC HEALTH CARE PLAN

This information will be shared with school staff members who are working with your child and who may need to know. Please contact the school nurse if you have any additional concerns or information. The school nurse will contact you if additional clarification is needed or another care plan is required. This health plan will remain in effect for the school year, or until the student's health status or physician's orders change. It is the responsibility of the parent to notify the school nurse at 719-342-1265 whenever there is any change in the student's health status or care.

Student's Name: _____ Date of Plan: _____

What is the health condition or concern? _____

_____

Parent/Guardian Name: _____ Home Phone: _____

Guardian's Work Phone: _____ Additional Guardian's Work Phone: _____

Primary Care Physician: _____ Phone: _____

Specialist Care Physician: _____ Phone: _____

What are the special considerations for school (describe: asthma triggers, activity restrictions, special diet, seizure precautions, other instructions, etc. that apply to school)? _____

_____

_____

_____

Please list any/all known allergies: _____

_____

Medications: (include those taken at home and school)

Name of Medication(s) Dosage Time Taken at Home Time Taken at School

_____

_____

_____

_____

_____

Illnesses, hospitalizations, accidents, injuries: _____

_____

_____

Diet Restrictions: _____

Health Equipment: _____

Call parent if: _____

Call 911 if any of the following occur: _____

Field Trips: _____

Any special instructions to handle an emergency? _____

Please circle if there is an <u>additional SPECIALIZED health care plan</u> for the following:

ADD/ADHD Asthma Diabetes Severe Allergy Seizures Other

Due to my child's health condition and potential risk for an emergency, I authorize the school nurse to share this information with Emergency Medical Services (EMS) and to emergency responders as necessary in the event of an emergency. As parent/guardian of this student, I give permission for this plan to be available for use in my child's school and for the school nurse to contact the above named physician(s) by phone, fax, or in writing when necessary to complete this plan.

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PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

PHYSICIAN SIGNATURE (Optional): _____ DATE: _____

SCHOOL NURSE SIGNATURE: _____ DATE: _____