**Student Information**

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |  | D.O.B. |  |
| Address: |  |

**Parent/ Guardian 1 Parent/ Guardian 2**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name: |  |  | Name: |  |
| phone #: |  |  | Phone #: |  |
| Email: |  |  | Email: |  |
| Work phone #: |  |  | Work phone #: |  |

**Primary Care Doctor**

|  |  |
| --- | --- |
| Doctor’s name/Office: |  |
| Phone number: |  |

**Health Insurance**: [ ] Private [ ] Medicaid [ ] None **Support Plan in place?** [ ]  504 [ ] IEP

**Medical History – Diagnosed by a medical provider**

|  |  |  |  |
| --- | --- | --- | --- |
| **Diagnosis** | **Yes** | **No** | **If Yes, please explain…** |
| Vision difficulties |  |  | Wears glasses? [ ] yes [ ] no |
| Hearing difficulties |  |  | Uses hearing aid? [ ] yes [ ] no |
| Speech difficulties |  |  |  |
| AllergiesList all allergies: |  |  | [ ] food [ ] environmental [ ] seasonal [ ] Other: \_\_\_\_\_\_\_\_\_\_Prescribed Epi-Pen? [ ] yes [ ] no **Provide Allergy Action Plan and Epi-Pen to school nurse** |
| ADD/ADHD |  |  |  |
| Asthma |  |  | **Provide inhaler and Asthma Action Plan to school nurse** |
| Autism |  |  |  |
| Bleeding Disorder |  |  |  |
| Cerebral Palsy |  |  |  |
| Developmental Delay |  |  |  |
| Diabetes |  |  | Insulin dependent? [ ] yes [ ] no **Provide Diabetes Care Plan to school nurse** |
| Feeding tube/ nutrition |  |  |  |
| Heart Condition |  |  |  |
| Lactose intolerant |  |  | **Provide doctor’s note to school nurse for milk substitute** |
| Migraines |  |  |  |
| Seizures |  |  | **Provide Emergency medication and Seizure Action Plan to school nurse** |
| Sickle Cell  |  |  |  |
| VP Shunt |  |  |  |
| Other: |  |  |  |

**Prescribed Medications**

|  |  |
| --- | --- |
| List medications: |  |
| If medication can be given at home before or after school hours, please do so. **If your child has a medication that must be given during the school day, a medication administration form is required to be on file with the school nurse.** Prescription or OTC |

**Emergency Contacts that are authorized to pick up student**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name/ Relationship: |  |  | Name/ Relationship: |  |
| Phone: |  |  | Phone: |  |
|  |  |  |  |  |
| Name/ Relationship: |  |  | Name/ Relationship: |  |
| Phone: |  |  | Phone: |  |

**Note to Parent/ Guardian**: This information will be kept confidential. In case of an emergency and you cannot be reached, the parent or guardian is responsible for any hospital, doctor or ambulance expense incurred in the best interest of your child. By signing this form your school nurse has permission to contact your medical provider as needed.