

ST. ELIZABETH SCHOOL
HEALTH INFORMATION FORM

THIS FORM MUST BE filled out and SIGNED BY a parent and SUBMITTED TO THE SCHOOL NURSE prior to the start of school.

NAME _____ BIRTH DATE _____ SEX _____ GRADE _____ Year _____
Parent(s)/Guardian(s): _____ Phone #1 _____ Phone #2 _____
Family Physician _____ Phone _____ Family Dentist _____ Phone _____

Student Health Concerns

Please X all that may apply. If your child has experienced or currently diagnosed and is receiving medical care for any of the following:

- | | |
|-------------------------------------------------------------------|-------------------------------------------------------------------------------------------|
| <input type="checkbox"/> ADD/ ADHD | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Digestive (stomach) concerns/gastric reflux |
| <input type="checkbox"/> Behavior/ Emotional Concerns | <input type="checkbox"/> Headaches/Migraines |
| <input type="checkbox"/> Blood/Bleeding Problems | <input type="checkbox"/> Heart Problems (current or history of heart problems) |
| <input type="checkbox"/> Bone/Muscle/ Joint Problems | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Bowel and/or Bladder Problems | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Sickle Cell Anemia |
| <input type="checkbox"/> Concussion (past)/Traumatic Brain Injury | <input type="checkbox"/> Skin Conditions (eczema, infections, reactions to insects, etc.) |
| <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Surgery/Hospitalizations (past/current) |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Other _____ |

Please explain any conditions above.

If there are special concerns, medications, treatments, or potential risk problems are an indication for your child, the school nurse or designated staff will contact you.

1. EYE/ EAR/ NOSE/ THROAT: Does your child have (Yes or No)

- Vision problems? Explain: _____
- Glasses? When does your child need to wear them? _____
- History of ear infections? Ear tubes? Y/N _____
- Hearing loss? If so, does it affect classroom performance, participation at recess or in PE? Explain _____

2. RESPIRATORY: Has your child experienced or diagnosed with (Yes or No)

- Asthma or reactive airway? At what age? _____ Does your child use medication? Y/N _____ (if yes please list below)
- Will your child need medication(s) at school? Y/N _____ (if yes, see diocese/school medication policy)

3. ALLERGIES:

- Allergies to medication(s) _____ Animal(s) _____ Seasonal _____
- Allergies Food(s) _____ Severe Y/N _____
- Does your child have Emergency medication? Y/N _____ does your child have a need for medication at school? Y/N _____ (if yes please list below)

List prescription and over the counter medications, your child takes regularly at home. (Medication name, amount, time)

❖ **All PK/PS, Kindergarten and new students** must supply copy of current/updated immunization record prior to start of school.

❖ **Current students (6th-8th)** if received Tdap and meningococcal booster (required by start of 8th grade), send copy of the updated immunization record before the start of school.

❖ **Current students (1st-5th)** if there are any updates/boosters received; Send a copy of the updated immunization record to school. (SNAP Health Portal: when summited using portal, you are able to use the electronic signature feature).

I understand that only pertinent information regarding my child's condition may be shared with school staff who are directly involved with my child and his/her care in the school setting.

Parent Signature _____ **Date** _____

I **do not** want this information shared with staff who are directly involved with my child and his/her care in the school setting.

Parent Signature _____ **Date** _____