Corvallis School District # 1

# Student Health Information Form

Student's Name: ______________________________________________ Grade: ____________
*Last* *First* *Middle Initial*

**If your child has a serious medical condition, it is vital that you discuss this with the School Nurse immediately. We must be alerted to LIFE THREATENING HEALTH CONDITIONS prior to your child's first day at school. These conditions may require an Individualized Health Plan**.

*The information you provide about your child's health conditions may be disclosed to your child's teacher(s) and other school staff as needed to provide for your child's health and safety at school Please check any conditions that apply and give additional information as indicated.*

## LIFE THREATENING HEALTH CONDITIONS:

**If you check any of these boxes you must contact the School Nurse**

☐ **ALLERGIES: Severe, with an epinephrine prescription**

Allergen(s): ______________________________

Describe previous symptoms or reactions your child had: ______________________________

What medications were used to treat those symptoms? ______________________________

Has your child ever been given a written prescription for epinephrine (Epipen)? ______________________________

☐ **ASTHMA or REACTIVE AIRWAY DISEASE:** *(If this box is checked, please answer the following questions)*

What medications does your child use for asthma? ______________________________

Will your child have an inhaler in the school office? Y N Will your child carry an inhaler in their backpack? Y N

Has your child been hospitalized for asthma in the past year? Y N

Has your child used steroids (prednisone) for asthma symptoms in the past year? Y N

What "triggers" cause asthma symptoms in your child? ______________________________

☐ **DIABETES:**

Type ____________ Date of diagnosis ________ Medications ____________ Pump____ Injections ____

☐ **SEIZURE DISORDER:**

Type ____________ Date of last Seizure________ Has orders for emergency seizure medication during school day? Y N

## NON - LIFE THREATENING HEALTH CONDITIONS:

☐ **ADD/ADHD:** ______________________ **Is medication required?** Y N **During School hours?** Y N

☐ **Allergies:** Allergen(s)______________________ Reaction ______________________

☐ **Developmental:** ______________________ **Is medication required?** Y N **During School hours?** Y N

☐ **Hearing concerns:** Does your child wear hearing aids? Y N Does your child have a known hearing loss? Y N

☐ **Vision concerns:** ______________________ Glasses Y N Contacts Y N

Other Health Concern(s):______________________________

## OVER-THE-COUNTER MEDICATIONS:

☐ Yes, I give my permission for my child to have a "school provided" cough drop or sore throat lozenge, if needed

☐ No, I do not want my child to receive any "school provided" cough drops/sore throat lozenges.

*If you are aware of the need and are able, please provide your child with cough drops/sore throat lozenges. (to be kept in the office)*

*Medications that must be given during the school day require an annual/permission form signed by both the primary care provider and the parent. To ensure the safety of all our students, parents must bring all medications to the school office in the original pharmacy or manufacturer labeled container. All medications, except for life saving medications, (epipen, inhalers and diabetic medications) that the student has been authorized to carry must be kept in the school office. Please ask the school secretary for the correct forms or print them from our school website.*

*Parent/Guardian Signature:*______________________________ *Date:*____________________