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 or office personnel. 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. Administration of prescription medication during school hours will require a physician's order.

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 will be contacted by 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:**

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 D**uring School hours?** Y N

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

☐ **Developmental:** _____ **Is medication required?** Y N D**uring 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 receive OTC pain reliever in standard dosage amount:

Circle One: Ibuprofen 200 mg Tylenol 325 mg ***Specify Quantity:*** _____

If taken with some frequency, please provide the office with medication in the original container labeled with your child's name.

Medications that must be given during the school day require an annual physician order 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:*_____