ANNUAL STUDENT HEALTH CONCERNS DOCUMENT

This questionnaire is designed to aid school staff in anticipating any health concerns that might affect your student's safety or learning.

Student Name _____ **School Year** _____

School _____ **Grade** _____ **Sex** _____ **Date of Birth** _____

LIFE THREATENING ALLERGY

Requiring an Epinephrine Auto Injector in school and medical follow-up. ** *Must contact school nurse*

☐ **Life threatening allergy to:** _____

_____

_____

☐ Other **Allergies, Not Life-Threatening** but needs to avoid:

_____

ASTHMA:

☐ Intermittent:- Student who has symptoms of wheezing and coughing no more than 2 days a week, with nighttime flare-ups twice a month or less. Outside of these few episodes, free of symptoms.

☐ Mild –Symptoms occur more than twice a week but less than once a day, flare-ups may effect activity.

☐ Moderate –Symptoms occur daily, flare-ups usually last several days. Symptoms disrupt normal activities and make it difficult to sleep.

☐ Severe –Symptoms occur daily and often, also curtail the student's activities and disrupt sleep.

☐ Inhaler/medications at school *see instructions below

ATTENTION DEFICIT DISORDER:

☐ Medication at school ***see instructions below**

☐ Medication at home

☐ Diagnosed, un-medicated

DIABETES:

****must contact the school nurse**

☐ Insulin dependent and will need a school program set up

☐ Not insulin dependent and will need school program set up

HEARING CONCERNS:

☐ History of hearing loss: right ear ____ left ear ____

☐ Wears hearing aid in left and/or right ear (circle one)

VISION PROBLEMS:

☐ Blind in one eye: right eye ____ left eye ____

☐ Other vision issue:_____

☐ Wears Glasses ☐ Wears Contacts

SEIZURES:

****must contact school nurse**

☐ Medication at school * **see instructions below**

☐ Medication at home

☐ History of seizures, but not presently medicated

Date of Last Seizure: _____

PHYSICAL RESTRICTIONS THAT WOULD LIMIT ACTIVITY:

☐ Skeletal (bone) or muscular limitations:

_____

OTHER HEALTH OR MEDICATION NEEDS:

☐ Medication your child needs at school not listed:
***see instructions below**

_____

ADDITIONAL HEALTH CONCERNS THAT WOULD AFFECT SCHOOL PERFORMANCE:

_____

_____

_____

_____

* **MEDICATION AT SCHOOL: Must submit Authorization for Administration of Medication at School, which can be obtained from the school office or on the BSD website. This form must be completed by a Licensed Health Care Provider before medication can be given.**

** **LIFE-THREATENING CONDITION: Must contact school nurse! A healthcare plan and all medications must be in place with the school before the student can attend school.**

AUTHORIZATION FOR EMERGENCY PROCEDURE

If the parents and Licensed Health Care Provider named on the registration record cannot be reached at the time of an emergency and if immediate observation or treatment is urgent in the judgment of the school authorities, I authorize and direct the school authorities to send my child (properly accompanied) to the hospital or Licensed Health Care Provider most easily accessible. I understand that I will assume full responsibility for the payment of any service rendered.

The above checked health concerns may be shared with school personnel on a "need to know" basis.

Parent/Guardian Signature: _____ ***Date:*** _____

Formerly: 1-13-2012
Last Revised: 2-8-2016