

Student Health Information



School	Teacher		Grade		
0			D: 11 D .	,	
Student Name			Birth Date	//	
Last Firs	t Mide	dle Initial	Male	☐ Female	
Does student have health insurance?	dicaid Private like information on Healt	☐ Non thy Kids, MI(_	es 🗌 No	
Does student have a doctor that they regular	y see? Yes	☐ No			
Doctor's Name & Phone		Date of last physical			
Dentist's Name		Date of last	visit		
Does Student Have Any Of The Following:					
Medication Allergies:	_ Emergency Treatme	nt Needed	Treatment		
Prescription or Over The Counter	Yes N				
Seasonal Allergies:			Treatment		
Food Allergies:			Emergency Plan and I	Medication at School	
	Yes	No	Yes No		
Sting Allergies:	Emergency Treatment		Emergency Plan and I Yes No	Medication at School	
Asthma Triggered by:	Inhaler Yes	☐ No	Emergency Plan and I	Medication at School	
Diabetas	Nebulizer Yes	No	Yes No Emergency Plan and I	Madiantian at Caban	
Diabetes Desired Blood Sugar Range:	_ Uses Insulin ☐ Yes	. □ No	Yes No	viedication at School	
Epilepsy/Seizure Disorder Last Seizure:			Emergency Plan at Sc	hool	
Describe Seizure:			Yes No		
Heart Condition Describe	Medication Yes		Restrictions Yes No		
List any serious illnesses, surgeries, injuries o	r concussion				
Eyes ☐Glasses ☐Contact Lenses	Other				
Ears Tubes Frequent Infections	Hearing Aid	Difficulty I	Hearing (Explain)		
Other (check those that apply)	☐ Blood/Bleeding D	Disorder	Mental Healt	th Issues	
ADD/ADHD	Dental Problems		Nosebleeds		
Birth Defects	Eating Disorder		Skin Problem		
Bladder/Bowel Problems	Headaches		Sleeping Pro		
☐ Blood Pressure Problem		blems	Special Educ	ation	
Describe anything checked above:					
What medications are taken regularly?					
Modication	700 T	i m o.	Durnoso		
Medication: Do Medication: Do					
Medication:					
Medication: Do					
		_			
Parent/Guardian Signature:		Date	9:		



Community School Nursing Program Consent for Treatment



Student Name		Birtho	date/_	/
	ergency care. In addition, the s	ngs, BMI measurement/data collection chool nurse may administer any o		
 OTC Antibiotic Ointm OTC Antihistamine Comment Anti-Fungal Topical Comment Eucerin Lotion (for Domain Acetaminophen (Tylen Ibuprofen (Advil) OTC Oral Loratadine Cough Drops/Throat Lorajel for tooth pain 	ream	ewable Antacid Tablets (Tums) age apadryl/Calamine Lotion C Hydrocortisone 1% Cream rer Sulfadiazine 1% Cream (Silvadene C Oral Diphenhydramine HCL (Benarile Wash for Skin & Eyes ne Eye Drops (Non-medicated) a Glucose	e for burns)	action)
Administration Authori	zation Form to be completed l	school staff or are self-carried by by the Parent & Physician prior to pensed by a physician/pharmacist	administration.	ALL medications
 I verify that I am authoriz 	ed to sign consent for the perso	on named in this document.		
1 verify that I am authorize				
 I further consent to release follow-up care for assessr 	ment/treatment provided, coord	primary/specialist care provider, a lination of care or school services. ntil the student changes school b		nnel regarding
 I further consent to releas follow-up care for assess This Consent will be in example. 	ment/treatment provided, coord	lination of care or school services.	ouildings.	
 I further consent to releas follow-up care for assess This Consent will be in example. 	ment/treatment provided, coord effect from the date signed un ithdraw my consent at any time	dination of care or school services. Intil the student changes school b	ouildings.	
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