

SCHOOL HEALTH INFORMATION FORM

PART 1 Parent Or Guardian To Complete. Parent or guardian is encouraged to participate in the development of an Individual Health Care Plan if needed.

Student Name Last	First	Middle	Sex M F	Date of Birth
School	Grade	Parent/Guardian Name		
Home Phone	Mother Cell	Father Cell		
My child has a medical condition that may affect his or her school day		NO	YES (please complete Part 2)	
Parent or Guardian Name (Print or Type)			Email Address	
Parent or Guardian Signature			Date	

PART 2 Complete All Boxes That Apply To Your Child. Parent/guardian is responsible for providing the school with any medication, special food, or equipment that the student will require during the school day. Check with the school office to obtain correct medication forms. If an individual school health care plan is indicated, parent/guardian is responsible for providing the school nurse with necessary medical information and forms. Please see [link to locate your building's school nurse and forms www.pccsk12.com/departments/health-safety](http://www.pccsk12.com/departments/health-safety)

ALLERGIES

Allergy Type

Food List food(s) _____

Bee/Insect Sting _____

Other (list) _____

Reactions **Type** Mild Severe Date of last severe reaction

Describe your child's allergic reaction symptoms: _____

Does your child require classroom designation (i.e. peanut, nut, dairy, or seafood "free" etc.)? NO YES

Does your child need to sit at a specified allergy free area in the cafeteria? NO YES

Will your child be riding the bus to school? NO YES

Currently prescribed medications and treatments

Oral antihistamine (Benadryl, etc.) Epinephrine Other _____

(A Medication Authorization Form is required for all meds at school. See next page)

FOOD INTOLERANCE

Due to Gastrointestinal (Digestive) distress List Foods _____

Due to Religious preferences List Foods _____

ASTHMA

Triggers Exercise Environmental Other (list) _____

Symptoms

Chest tightness, discomfort, or pain Difficulty breathing Throat itch, tightness, or soreness

Coughing Hoarseness Wheezing

Other _____ Date of last hospitalization for asthma _____

Currently prescribed medications and treatment

Inhalers Oral antihistamines Oral steroids Nebulizer Oral Bronchodilator Peak flow monitoring

Will your child require medication at school? NO YES

(A Medication Authorization Form is required for all meds at school. See next page)

CONTINUE ON REVERSE

Diabetes (Contact School Nurse to discuss Individualized Health Plan)

Currently prescribed medications and treatments

Insulin Syringe Pen Pump

Blood sugar testing Carbohydrate Counting

Glucagon Oral medication(s) List medication(s) _____

Date of last hospitalization related to Diabetes _____

Seizure Disorder

Type of seizure

Absence (staring, unresponsive) Complex partial Generalized tonic-clonic (grand mal, convulsive)

Other (explain) _____

Date of last seizure _____ Length of seizure _____

Physical education restrictions NO YES

Currently prescribed medications _____

Medications needed **IN SCHOOL** NO YES List medication(s) _____

(A Medication Authorization Form is required for all meds at school. See below)

Other Health Conditions

ADHD/ADD Arthritis Bathroom Issues Bleeding disorder (be specific) _____

Emotional concerns Heart Condition (be specific) _____

Kidney Disease Physical disability (be specific) _____

Other (explain) _____

Special procedures (e.g. catheterization, cardiac monitor, etc.) required **IN SCHOOL** NO YES

(explain) _____

Medication needed IN SCHOOL NO YES

List Medication(s) _____

A Medication Authorization Form must be completed by your child's physician for all medication (prescription and over-the-counter) indicating the medication, dosage, and time the medicine is to be given. See "School Health" link on the district website for policy and forms. <http://www.pccsk12.com/departments/health-safety>

Vision Conditions

Hearing Conditions

Contacts Glasses Non Correctable

Hearing aid(s) Non Correctable

Other _____

Other _____

Physical Restrictions

Does your child's health condition restrict participation in Physical Education? NO YES

If Yes, please explain restrictions _____

Will your child be riding the bus to school? NO YES

PART 3 School Nurse to Complete if parent or guardian indicates medical condition(s).

Health Condition noted Individual health care plan or procedure needed

P-CCS School Nurse

Date

Notes _____

RETURN COMPLETED FORM TO SCHOOL OFFICE