Corvallis School District # 1

Student Health Information Form

Student Name: ____ **Grade:** ___________

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 aware of LIFE THREATENING HEALTH CONDITIONS prior to your child's first day at school. These conditions may require an Individualized Health Plan.

PRESCRIPTION MEDICATIONS:

- **Does your child have a prescription for daily medication that will be taken at school? Y N**

Medications 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 (epi-pen, 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.

LIFE THREATENING HEALTH CONDITIONS:

If you check any of these boxes, the School Nurse will contact you.

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

Allergen(s): ____

Describe previous symptoms or reactions your child had: ______________________________________

What medications were used to treat those symptoms? ____

Did your child ever receive a written prescription for epinephrine (Epi-pen)? _______________________

☐ **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 **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 Is there known hearing loss? Y N

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

Other Health Concern(s): ____

This information may be disclosed to your child's teachers and school staff to provide for your child's safety at school.

Parent/Guardian Signature: ____ **Date:** ___________________