Student Health Information

Hutchinson Public Schools USD 308
2018-2019

Please fill out the following form. This information enables school personnel to be more aware of health-related concerns and provide more personalized health care as needs arise. This information is part of the online enrollment process.

Student's Name: _____ Student's Date of Birth: _____ Grade: _____

School: _____ Physician: _____

☐ **My child is healthy and has no present health concerns at this time.** (Parent signature is required at the bottom of the page.)
Note: Administering medication at school should be avoided whenever possible. If possible, give medications before school, after school, in the evening or at bedtime instead.

Hearing		**Vision**	
☐	Deafness - Right Ear	☐	Wears Glasses
☐	Deafness - Left Ear	☐	Wears Contacts
☐	Wears Hearing Aides	☐	Blindness - Right Eye
☐	Frequent Ear Infections	☐	Blindness - Left Eye
☐	Ear Surgery - Explain:	☐	Other Vision Concerns:
☐	Other:		
		Neurological Conditions	
Behavior Related		☐	Concussion/Head Injury
☐	ADD	☐	Frequent Headaches
☐	ADHD	☐	Migraine Headaches
☐	Anxiety	☐	Diagnosed by Dr. _____
☐	Bipolar	☐	Requires Medications at School - If checked, the RX Medication Form and Release of Information must be filled out and signed by a parent or guardian AND physician.
☐	Depression		
☐	ODD		Explain Treatment Needed at School for Migraines:
☐	Other:	☐	Diagnosed with Seizure Disorder - If checked, the Seizure Action Plan, RX medication form and Release of Information must be filled out and signed by a parent or guardian AND physician.
Treatment Medications Please list:			Date of Last Seizure: Type of Seizure:
Treated by Dr. _____			Date of Onset:
☐	Requires Medications at School - If checked, the RX Medication form and Release of Information must be filled out and signed by a parent or guardian AND physician.	☐	Requires Emergency Seizure Medication at School - If checked, the Seizure Action Plan, RX medication form and Release of Information must be filled out and signed by a parent or guardian AND physician.
Allergies		**Asthma**	
☐	Food Allergy	☐	Takes Prescribed Asthma Medication
	List Food Allergies:		List Asthma Medication:
☐	Lactose Intolerance		
☐	Dietary Restrictions - If checked, the Meal Modifications form and Release of Information must be filled out and signed by a parent or guardian AND physician. The completed Meal Modification form must be turned into the school secretary.	☐	Requires Asthma Medications at School - If checked, the Asthma Action Plan, RX Medication form and Release of Information must be filled out and signed by a parent or guardian AND physician.
	List Restrictions:	☐	Nebulizer:

		☐	Inhaler:
☐	My child has a food allergy AND will be eating a school provided lunch.		
☐	Seasonal Allergies	**Heart Condition**	
☐	Bee/ Wasp Sting	☐	High Blood Pressure
☐	Medication/Drug Allergy:	☐	Low Blood Pressure
		☐	Mitral Valve Prolapse
☐	Epi-Pen	☐	Congenital Heart Defect
☐	Inhaler	☐	Limitations/Restrictions at School
☐	Antihistamine	Limitations Prescribed by Dr. _____	
☐	Requires Emergency Allergy Medication at School - If checked, the Allergy Action Plan, RX medication form and Release of Information must be filled out and signed by a parent or guardian AND physician.	If your child has prescribed limitations, USD 308 requires a physician note stating your child's limitations/restrictions and Release of Information be given to your school nurse **prior to the first day of school.**	
Diabetes/Hypoglycemia/Metabolic Syndrome		**Digestive**	
☐	Type I Diabetes	☐	Heartburn/Indigestion
☐	Type II Diabetes	☐	Reflux
☐	Medication Name:	☐	Constipation
☐	Hypoglycemia	☐	Other, Please Specify:
☐	Metabolic Syndrome		
Diagnosed by Dr. _____ The Current Diabetic Orders/Diabetes Action Plan, RX Medication forms for Insulin and Glucagon, and Release of Information must be filled out and signed by a parent or guardian AND physician. Parent or guardian must also make arrangements with the school nurse to meet **one week prior to the first day of school** to develop an individualized health care plan to ensure the safety of your child while at school.			
		Other Illnesses/Conditions	
		List any Other Illnesses:	
		List Medications for any Other Illnesses or Condition:	
Orthopedic			
List concerns:		Diagnosed by Dr.	
☐	Limitations/Restrictions at School - If checked, USD 308 requires a physician note stating your child's limitations/restrictions and Release of Information be given to your school nurse **prior to the first day of school** and /or on the dates of the limitations/restrictions.	☐	Hospitalizations:
		☐	Surgeries:
			If medications are required at school, the OTC Medication form and/or RX Medication form and Release of Information must be filled out and signed by a parent or guardian AND physician.

Parent/Guardian Responsibility:

- Notify the school nurse of child's health care needs.
- Work with the school staff to develop a plan that accommodates the child's needs during meals, in the classroom, and all school activities.
- Meet before each school year to review the appropriate action plan as needed.
- Provide written medical documentations, instructions and medications as directed by a physician.
- Provide updated parent/guardian contacts and emergency contact information and address.
- Review the parent-student information booklet related to medications at school and also provide properly labeled and/or maintain the appropriate medications and action plans to ensure the safety of your child while at school.
- Give permission to share health information with staff on a need to know basis.
- All needed forms must be completed and given to your child's school nurse prior to the first day of school.
  All additional forms can be accessed at www.usd308.com/HealthForms

Name of Person Completing Form: _____

Relationship to Student: _____ **Date Completed:** _____