Cole R-1 School District

Student Health Information

This form must be completed each year

STUDENT INFORMATION

Your child's learning depends upon good health. To assist in providing health services at school, please complete the following.

Last _____ First _____ Middle _____

Grade _____ Gender: ☐ M ☐ F Date of Birth (mm/dd/yy): _____

Teacher (leave blank if NEW Student Enrollment) _____

Parent/Guardian _____ Home Phone _____

Father's Employer _____ Mother's Employer _____

Father's Work Phone _____ Mother's Work Phone _____

Father's Cell Phone _____ Mother's Cell Phone _____

EMERGENCY CONTACT INFORMATION -- Other Than Parents

Name _____ Relationship to Student _____

Phone Number _____

Name _____ Relationship to Student _____

Phone Number _____

MEDICAL INFORMATION

Doctor's Name _____ Phone Number _____

Dentist's Name _____ Phone Number _____

Hospital Preference: ☐ Capital Region Medical Center ☐ St. Mary's Hospital

Does your child have...

Allergies ☐ Yes ☐ No
(foods, drugs, latex, etc.)
Please list: _____
Has the allergy required emergency action in the past? ☐ Yes ☐ No
Comments: _____

Bee Sting Allergy ☐ Yes ☐ No
Describe reaction: _____
Any difficulty breathing? ☐ Yes ☐ No Need emergency medication? ☐ Yes ☐ No

Asthma ☐ Yes ☐ No
Triggered by: _____
Treatment: _____
Diagnosed by doctor (name): _____
Date diagnosed: _____

Diabetes ☐ Yes ☐ No
Takes Insulin: _____
Date diagnosed: _____

Epilepsy/Siezures ☐ Yes ☐ No
Describe seizure: _____
Date of last seizure: _____
Medication: _____

Heart Condition ☐ Yes ☐ No
Describe condition: _____
Physical restrictions: _____

Bone or Joint Problem ☐ Yes ☐ No
Describe: _____
Physical restrictions: _____

Emotional/Behavior ☐ Yes ☐ No
Diagnosis or description: _____
Treatment (doctor, counselor, etc.) _____

Daily Medications

At Home? ☐ Yes ☐ No Name of Medication: _____
Dosage Time: _____

At School? ☐ Yes ☐ No Name of Medication: _____
Dosage Time: _____

Emergency Only? ☐ Yes ☐ No Name of Medication: _____
Dosage Time: _____

Eyes

☐ glasses ☐ reading ☐ distance ☐ contacts ☐ crossed ☐ lazy eye ☐ difficulty seeing ☐ headaches

Ears

☐ frequent infections ☐ tubes ☐ hearing difficulty ☐ history of hearing problems in the family
☐ talks loudly ☐ hearing aid --- ☐ left ☐ right wears hearing aid at school ☐ Yes ☐ No

Other Concerns

☐ nosebleeds ☐ bowel ☐ bladder ☐ diapers ☐ catherization ☐ bedwetting ☐ headaches ☐ lungs
☐ skin ☐ ADD / ADHD ☐ neurological ☐ blood disorder ☐ blood pressure ☐ menstruation

Childhood diseases, serious illnesses, and injuries: _____

Surgeries: _____

Low Birth Weight: ☐ Yes ☐ No

Any condition(s) that prevent PE participation: _____

DIETARY NEEDS

Special Diet: _____ Doctor who prescribed the diet: _____

Will your child require food substitution? ☐ Yes ☐ No

A specific form signed by a licensed physician is required before allowing meal or drink substitutions at school. This form can be obtained in the nurse's office or on the school website.

Requires special health care (explain): _____

Other health information or concerns: _____

Special procedures required: _____

If the School Nurse is expected to administer medication (Prescription or Non-prescription) to your child, a **MEDICATION FORM** must be completed and on file (see school website). When the medication is changed, a new form must be submitted. Medications **MUST BE** in the original bottle and ***brought in by the Parent***.

Please circle below ALL medicines the Cole R-1 School District has your permission to give your student.

Acetaminophen(Tylenol) Ibuprofen Aleve Tums Cough Drops

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

I understand the information given above will be shared with appropriate school staff to provide for the health and safety of my child. If either I or an authorized emergency contact person cannot be reached at the time of a medical emergency, I authorize and direct school staff to send my child to the most easily accessible hospital or physician. I understand I will assume full responsibility for payment of any transport or emergency medical services rendered.

_____ _____

Parent /Legal Guardian Signature Date