Health Concerns

Student Name:_____ **DOB:** _____

For Office Use Only: *Completed Medication Orders* ☐ *Medical Supplies Received* ☐ *Medications Received* ☐

This information is needed to plan an appropriate program for your student and to prepare for any emergency situation, if one should arise. Your building nurse will contact you if there are any additional questions. This form is to be completed by the parent/guardian. **The law requires that life threatening conditions such as anaphylaxis, asthma, diabetes, or seizures have a completed care plan, completed medication orders, medical supplies and medication(s) supplied to the school prior to the student's first day of school. Please contact the building nurse as soon as possible to ensure the paperwork is complete.**

Does your child have any current health conditions? ☐ Yes ☐ No *If yes, fill in all appropriate information. If no, skip to signature on page 2.*

Medical History *(Indicate all that apply)*
Life Threatening Health Condition *(please contact nurse for care plan)*

- ☐ *Hemophilia
- ☐ *Diabetes Type I
- ☐ *Anaphylactic Condition (EpiPen)
- ☐ *EpiPen prescribed
- ☐ *Asthma
- ☐ *Seizure Condition
- ☐ *Cardiac Condition

Cardio Vascular

☐ Diagnosed Condition:_____

Please explain:_____

Hematology (Blood)

- ☐ Sickle Cell Anemia
- ☐ Other blood condition, explain: _____

Endocrine, Allergy, Immune System

- ☐ Food Allergy — List Allergy: _____
- ☐ Insect Allergy — List Allergy: _____
- ☐ Cystic Fibrosis
- ☐ Thyroid Disease
- ☐ Diabetes Type II
- ☐ Other:_____

Gastrointestinal-Intestinal, Dental & Oral Conditions

- ☐ Celiac Disease
- ☐ Crohn's/Colitis
- ☐ Lactose Intolerance
- ☐ Gastroesophageal Reflux
- ☐ Irritable Bowel
- ☐ Liver Disease
- ☐ Oral Condition
- ☐ Dental Condition
- ☐ Other: _____

Skin & Subcutaneous Tissue

- ☐ Contact Dermatitis
- ☐ Eczema
- ☐ Other:_____

Nervous System

- ☐ Autism
- ☐ Traumatic Brain Injury
- ☐ Cerebral Palsy
- ☐ Developmental Disability
- ☐ Migraines
- ☐ Headaches
- ☐ Sensory Condition
- ☐ Paralysis
- ☐ Speech Impairment
- ☐ Shunt
- ☐ Spinal Cord Injury
- ☐ Spina Bifida
- ☐ ADHD/ADD diagnosed
- ☐ Recent Concussion — Date of concussion:_____

Concussion diagnosed by:_____

- ☐ Other: _____

Mental or Behavioral Health Condition

- ☐ Sleep Disorder
- ☐ Anxiety
- ☐ Other: _____
- ☐ Depression

Respiratory

- ☐ Reactive Airway Disease
- ☐ Other: _____

Muskuloskeletal & Connective Tissue

- ☐ Juvenile Rheumatoid Arthritis
- ☐ Muscular Dystrophy
- ☐ Other: _____

Renal & Genitourinary

- ☐ Chronic Urinary Tract
- ☐ Dysmenorrhea (painful periods)
- ☐ Infection Incontinence
- ☐ Other:_____

Neoplasm (Cancer/Tumors)

Please explain: _____

Eye & Ear

- ☐ Visually Impaired
- ☐ Wears Glasses/Contacts
- ☐ Hearing Impaired
- ☐ Wears Hearing Aids
- ☐ Chronic Ear Infections
- ☐ Other:_____

MEDICATIONS: (Please report all medications that your student takes both at home and at school)

Is medication needed at home? Is medication needed at school? ☐ Yes ☐ No

Please list:_____

Medication at school? ☐ Yes ☐ No

Please list:_____

State law requires written permission from parent/guardian and a licensed health care provider before any medications, prescription, or over-the-counter medication, may be taken at school. Forms are available from the school health rooms, school office, or from the Arlington Public Schools website at: www.asd.wednet.edu/for_parents/district_forms.

If parent/guardian or authorized emergency contact cannot be reached at the time of a medical emergency, and if immediate care is urgent in the judgment of the school authorities, I authorize and direct the school authorities to send the student to the hospital or doctor most accessible. I understand that I will assume full responsibility for the payment of any services rendered. I understand that the information given above will be shared with appropriate school staff that needs to know in order to provide for the health and safety of my student.

I give permission to my child's school to add immunization information into the Immunization Information System to help the school maintain my child's record.

Parent/Guardian Name	Parent/Guardian Signature	Date
Parent/Guardian Name	Parent/Guardian Signature	Date