St. David Unified School District

Collaboration ❦ Positivity ❦ Preparedness

STUDENT HEALTH REGISTRATION FORM

This questionnaire is designed to aid school staff in anticipating any health concerns that might affect your child's safety or learning. **All students must have completed form on file every year.** Information will be stored in Student Health Records and will be confidential to the greatest extent allowable by law.

Student Name_____ Date of Birth_____ Grade _____

MEDICAL

Does your child have a doctor or nurse practitioner? ❑ Yes ❑ No

Name of child's doctor or nurse practitioner _____ Phone number _____

MEDICAL HISTORY

Have you ever been told by a physician or health care professional that your child has:

___ Asthma ___ Diabetes ___ Seizure disorder ___ Bone/muscle disease ___ Heart condition ___ Bleeding disorder ___ Skin condition

___ ADD/ADHD ___ Learning disability ___ Mental health condition (i.e., depression, anxiety, eating disorder) ___ Other _____

Does your child experience any of the following?

___ Nose bleeds ___ Frequent ear aches ___ Overweight for age ___ Physical disability ___ Poor appetite ___ Frequent stomach aches

___ Frequent headaches ___ Fainting spells ___ Tires easily ___ Emotional concerns ___ Underweight for age ___ Other_____

Do any of the above condition(s) limit/effect your child at school?_____

LIFE-THREATENING CONDITIONS

Does your child have a life-threatening health condition? ❑ *Yes ❑ No Describe:_____

***If yes, a meeting with the school nurse is required.**

ALLERGIES

❑ Plants ❑ Animals ❑ Food ❑ Molds ❑ Medication ❑ Bees ❑ Other: _____

Please describe the allergic reaction and the treatment for **each** checked allergy _____

Do you plan for your child to receive school prepared meals? ❑ *Yes ❑ No

***an additional form must be completed if your child has food or insect allergies.**

MEDICATION

Does your child take any medication? ❑ *Yes ❑ No

*If yes, name of medication:_____ Purpose_____ Will medication be needed at school? ❑ *Yes ❑ No

*If yes, name of medication:_____ Purpose_____ Will medication be needed at school? ❑ *Yes ❑ No

*If yes, name of medication:_____ Purpose_____ Will medication be needed at school? ❑ *Yes ❑ No

*If yes, name of medication:_____ Purpose_____ Will medication be needed at school? ❑ *Yes ❑ No

***If your child needs to take medication at school, please contact the office for the necessary authorization form.**

THIS FORM MUST BE COMPLETED PRIOR TO ANY MEDICATION BEING BROUGHT TO SCHOOL.

HEARING/VISION

Do you have concerns about your child's hearing? ❑ Yes ❑ No Does your child wear hearing aides? ❑ Yes ❑ No

Do you have concerns about your child's vision? ❑ Yes ❑ No Does your child wear glasses or contacts? ❑ Yes ❑ No

SPEECH/LANGUAGE

Do you have concerns about your child's speech and/or language? ❑ Yes ❑ No

Do others have difficulty understanding your child? ❑ Yes ❑ No If yes, please explain: _____

MEDICATION POLICY

All medications must be brought in original containers. Written parental permission must accompany all medicine, regardless if it is prescription or non-prescription. Order from the physician must accompany prescribed medication. (Printed prescription on medication bottle will be accepted for order from doctor for prescription medication.) Use the following medication: TYLENOL, IBUPROFEN, BENADRYL, DECONGESTANT (Pseudoephedrine), CALADRYL LOTION, BLISTEX, AMBESOL, TUMS, SORE THROAT SPRAY, HYDROCORTISONE CREAM, TOPICAL ATIBIOTICS, BURN GELL, EYE DROPS (Artificial Tears), COUGH DROPS/LOZENGES, ALLERGY MEDICATION (Fexofenadine) will be at the discretion of the District Nurse or personnel designated by the Principal. Regular use of these and any other non-prescription medications will require written physician's orders and are to be supplied by the parent/guardian.

PLEASE CHECK THE BOX THEN INITIAL BELOW:

❑ I DO _____ ❑ I DO NOT _____ Give my permission for the District Nurse or other personnel designated by the Principal to administer the above medications to my child.

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/Guardian Signature_____ Date _____

It is your responsibility to notify the office if any of the medical information on this form changes.