

# RUSH COUNTY SCHOOLS

## Health Form 2012-2013 School Year

Student Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Name \_\_\_\_\_

School \_\_\_\_\_ Grade for 12-13 \_\_\_\_\_ Date of Birth \_\_\_\_\_

**Check the following diseases this child has had and give approximate dates.**

Chickenpox _____	Rheumatic Fever _____	Allergies _____
Mononucleosis _____	Scarlet Fever _____	Others _____
Pneumonia _____	Whooping Cough _____	_____

Does this child wear glasses/contacts? \_\_\_\_\_ Yes \_\_\_\_\_ No

**Health Information**

Name of family doctor \_\_\_\_\_ Approximate date of child's last physical examination \_\_\_\_\_

Comments or recommendations made by examiner at that time \_\_\_\_\_

Present condition of child's health \_\_\_\_\_

Had child ever been examined or treated by other medical specialists? \_\_\_\_\_ Yes \_\_\_\_\_ No  
If yes, please explain \_\_\_\_\_

Please check if child has experienced problems with any of the following:

_____ Allergies	_____ Excessive Crying	_____ Tiredness	_____ Dizzy Spells
_____ Eating	_____ Physical Growth	_____ Eye Strain	_____ High Temperatures
_____ Headaches	_____ Loss of Consciousness	_____ Nervousness	_____ Other

Comments \_\_\_\_\_

What has the examiner reported to parents regarding the above? \_\_\_\_\_

Has the child ever had an illness, accident, or emotional experience which seems to delay social, emotional or physical growth?  
\_\_\_\_\_ Yes \_\_\_\_\_ No If yes, please explain. \_\_\_\_\_

Have there been any circumstances in the child's life that you believe were hard for the child and that you think would help us understand any problems the child might have? \_\_\_\_\_

**Current Medications**

Does the student take any medications (prescribed and/or OTC)? \_\_\_\_\_ Yes \_\_\_\_\_ No

Explain, including dosage, and frequency. \_\_\_\_\_

Is medication required during school hours? \_\_\_\_\_ Yes \_\_\_\_\_ No *(If yes, please obtain necessary form at registration of from nurse.)*

**Student Health Status**

Complete the following checklist by indicating any of the following conditions, past or present. Continue of back if more space is needed.

	Yes	No		Yes	No
Heart Problem/Defect			Hearing Deficit		
ADD/ADHD			Hepatitis		
Anemia (include Sickle Cell)			Surgery		
Arthritis			Activity Restriction		
Back/Neck Injury or condition			Physical Disability		
Blood/Clotting Disorder			Mononucleosis		
Cancer/Leukemia			Epilepsy		
Diet Restrictions			Vision Deficit		
Head Injury/Concussion			High Blood Pressure		
Headaches			Other		

Please give details for all that are marked **Yes** above. \_\_\_\_\_

Does your child have asthma? \_\_\_\_\_ Yes \_\_\_\_\_ No If yes, \_\_\_\_\_ Mild \_\_\_\_\_ Moderate \_\_\_\_\_ Severe

Does your child have allergies? \_\_\_\_\_ Yes \_\_\_\_\_ No If yes, nature of allergy \_\_\_\_\_  
If yes, \_\_\_\_\_ Mild \_\_\_\_\_ Moderate \_\_\_\_\_ Life-threatening \_\_\_\_\_ Epipen prescribed \_\_\_\_\_ Yes \_\_\_\_\_ No

Does your child have diabetes? \_\_\_\_\_ Yes \_\_\_\_\_ No  
If yes, insulin, glucometer, pump, and care needed at school \_\_\_\_\_

Does your child have seizures? \_\_\_\_\_ Yes \_\_\_\_\_ No If yes, describe type and meds taken \_\_\_\_\_

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**Consents and Signature**

The School Nurse has permission to contact my child's doctor if medically necessary. \_\_\_\_\_ Yes \_\_\_\_\_ No

Doctor \_\_\_\_\_

Dentist \_\_\_\_\_

Eye Doctor \_\_\_\_\_

\_\_\_\_\_ I understand that in order to provide the safest possible environment and most complete educational program for my child, the school needs to be informed of any health or medical conditions that may affect my child's school day or impact his/her learning.

\_\_\_\_\_ I understand that medications of any kind are not allowed on school grounds without the proper medical authorization on file. I understand that school staff, including the nurse MAY NOT administer or assist with any medications without the proper medical authorization on file.

\_\_\_\_\_ I understand that for the safety of my child, or to provide for their educational program, the school nurse may need to share information about my child's condition with appropriate school staff. This will be done in a confidential manner. If I do not wish that information shared, I must request this in writing and file it with the school nurse.

Parent Signature \_\_\_\_\_

Date \_\_\_\_\_