

CONFIDENTIAL STUDENT HEALTH INFORMATION

STUDENT:

Last Name First Name Middle Name Date of Birth Grade

Primary Contact in the event of an emergency during school hours:

Contact #1 _____ Phone # _____ Contact #2 _____ Phone # _____

Health/Medical Conditions: Check here if NONE or check all that apply:

Physical/Developmental Conditions			
<i>Allergies</i> <input type="checkbox"/> Bees <input type="checkbox"/> Food <input type="checkbox"/> Latex <input type="checkbox"/> Medication <input type="checkbox"/> Lactose <input type="checkbox"/> Gluten List Specific Allergies/Intolerances: _____ _____	Contacts/Glasses/Visual		Cerebral Palsy
	Diabetes Type I Insulin by <input type="checkbox"/> Pump <input type="checkbox"/> Injection		Spina Bifida
	Diabetes Type II		Seizure Disorder
	Dizziness/Fainting		Skin Rashes
Celiac Disease	Ear Infection/Tubes		Neuromuscular Degenerative Disorder
Constipation or Encopresis	Frequent Urination		Neurological Conditions: Other
<i>Blood Dyscrasias:</i> <input type="checkbox"/> Hemophilia <input type="checkbox"/> Sickle Cell <input type="checkbox"/> Von Willibrand <input type="checkbox"/> ITP <input type="checkbox"/> Other Blood Dyscrasias	Hearing Deficit		Nose Bleeds
	Gynecological/Menstrual Issues		Asthma (current or history) or Breathing (Respiratory) Disorder If yes, used asthma medication within past two years? <input type="checkbox"/> Yes <input type="checkbox"/> No (Describe below)
Cancer: Type: _____	Inflammatory Bowel Disease (IBS, Crohn's, etc)		
Cardiac Conditions	Kidney Disease		Pulmonary Hypertension
Autoimmune Disorder (Arthritis, Lupus, etc.)	Lyme Disease <input type="checkbox"/> Acute or <input type="checkbox"/> Chronic		Other Physical/Developmental Conditions
	Migraine Headaches		
	Neurological Conditions:		Thyroid Problems
Behavioral/Emotional Conditions			
ADHD/ADD	Depression		PTSD/Trauma History
Anxiety (GAD, School Phobia, etc.)	Eating Disorders		Other Behavioral/Emotional Conditions
Autism Spectrum Disorder			

Please provide additional details on health conditions that may require nursing services during the school day: _____

Uses adaptive equipment: hearing aides, sound field amplifiers, wheel chair, or crutches (list) _____

Takes daily medication (list Name, Dose, Frequency): _____

Is someone in this student's immediate family enlisted in the military? Yes No

If yes, list relationship(s) to student and branch(es) of service: _____

Health Provider Information

	Last Name	First Name	Phone No	None	
Primary Doctor	_____	_____	_____	<input type="checkbox"/>	Health Insurance <input type="checkbox"/> Yes <input type="checkbox"/> No Health Insurance Provider _____ Subscriber Name _____ Health Insurance # _____
Dentist	_____	_____	_____	<input type="checkbox"/>	

Permissions:

My child has my permission to receive health/wellness and support services. I understand the information on this form will be shared with appropriate school personnel in order to meet my child's safety and health care needs. I give permission to exchange information with my child's primary care physician for the purpose of referral, diagnosis and treatment.

In the event of a public health emergency, I give permission to the school nurse to administer **Potassium Iodide (KI)** (see attached KI information sheet). Parent Signature: Yes _____ No _____

I give permission to the school nurse to administer over the counter medications to my child per the **Newburyport Public Schools Medication Protocols** (see attached information sheet). To **refuse** one or more of the medications in this protocol, **please list here:**

Parent/Guardian Signature

Date