Collins-Maxwell School Health Information

This information will give the school nurse a background to your child's health and concerns he/she may have. This information will be considered confidential and will be kept with your child's health record.

Name: _____ Date of Birth: _____ Gender: M/F

Parent/Guardian Name: _____ Grade: _____ Teacher/Advisor: _____

Emergency Contacts (if parents are not able to be reached)—If your child needs to be taken home due to illness or injury and you cannot be reached, we will call the emergency contact person listed on the first page.

- Have these people agreed to assume this responsibility in case of emergency and agreed to take your child home if he/she becomes ill at school? **Yes/No**
- If we are unable to contact you or the above people, will you grant us permission to get medical treatment if we feel it is necessary? **Yes/No**

Family Doctor: _____ Phone:_____ Last physical exam: _____

Family Dentist: _____ Phone: _____ Last dental exam: _____

Eye Doctor: _____ Phone: _____Last eye exam date: _____
Lenses/contacts: Yes/No Full-time/Reading only

Has he or she had chicken pox: yes/no Date they had them: _____
Surgery/Serious illness/Injury/Hospitalizations:
_____

List any special dietary needs/restrictions (allergy to milk, diabetic, increase fiber, low cholesterol, etc:
_____
ANY SPECIAL DIETARY NEEDS *REQUIRE* A NOTE FROM YOUR PHYSICIAN!
Any Known Drug Allergies: Yes/No. If yes, please list: _____
Any Food Allergies: Yes/No. If yes, please list: _____
Any other allergies, please list: _____

Health Condition(s) – check/circle any of the following that your child has had, or currently is a concern:
_____ Toileting issues ____ Frequent nosebleeds _____ Frequent colds _____ Seizures _____ Diabetes
_____ Asthma/wheezing _____ Stomach aches _____ Heart Problems _____ Special Procedures
_____ Pneumonia/Bronchitis _____ Tube(s) in ear(s)--right/left/both _____ ADHD/ADD/ODD/OCD
_____ Frequent headaches _____ Migraines _____ Frequent sore throat, tonsillitis
_____ Eye problems: poor vision, crossed eyes, muscle imbalance _____ Other: explain below
Please explain any marked answers: _____

Medications: Is your child taking **ANY** medication (including inhalers, over-the-counter meds, etc.)? **Yes/No (Please attach a separate sheet if there are more medications)**
If **yes**: Medication: _____
Dose: _____
Times: _____
Purpose: _____
Doctor who prescribes the medication: _____
Please remember that ALL medications sent to school must be in any original Pharmacy labeled container and accompanied by a written permission to give them to your child at school!

At School Permission for the following: I give permission for my child to be given (please circle)
*Ibuprofen *Acetaminophen (Tylenol) *Antacid (Tums) *Cough Drops *Topical lotions to be applied if needed
Health information may be shared with pertinent school personnel Yes_____ No_____

Parent Signature: _____ Date: _____