Tina-Avalon R-II School Student Health Form

Student's Full Name: _____

Date of Birth: _____ Grade: _____ Male or Female

Address: _____Home Phone: _____

_____ County: _____

Parent/Guardian: _____

Emergency contact numbers: _____cell _____wk

Additional Person to contact in emergency:_____

Relationship: _____ Phone: _____cell: _____

Student's Physician:_____Phone:_____Date of last physical:_____

Student's Dentist: _____ Phone Number: _____

Date of last exam: _____ Does child have dental sealants? Yes No

If student is 6 years or under, has he/she been tested for lead? Yes No

Preferred Hospital: ___Hedrick Medical Center 646-1480 or ___Carroll Co. Memorial Hospital 542-1695

Health Concerns:

Child has health concerns: Yes No If yes, please complete the following (circle all that apply):

Eyes: glasses for reading glasses for distance contacts crossed lazy eye

other_____

Ears: frequent infections tubes hearing aid other _____

Allergies: (medication, food, insects, pollen, latex) please list and explain reaction

Seizures: Yes No cause: _____date of last seizure: _____ medication: Yes No

Other: nose bleeds blood disorder blood pressure neurological orthopedic headaches dental skin diabetes heart problem lungs bowel bladder menstruation phobias eating sleeping

other_____

Prescribed Daily Medications:

Medication _____Dosage _____ Time _____ Reason _____

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Permission to administer over the counter medication:

I grant permission for this child to receive the appropriate dosage for his/her age and weight of the following over the counter medication for pain, cough, sore throat, skin irritations, tooth pain, upset stomach, foreign object in eye or fever.

__Tylenol/Acetaminophen __Ibuprofen __Cough drops __ Lip Balm/Vaseline __Natural Tears eye drops ___Anti-Itch Cream

__First Aid/Burn/Antibiotic Ointment __Orajel/Oral Anesthetic __Benadryl for allergies /allergic reaction ___ Tums/Antacid

Does the child suffer from asthma? Yes No If answer is yes, please complete the following.

Asthma Health History:

How long has the child had asthma? _____

How many days would you estimate he/she missed last year due to asthma? _____

Name of child's doctor (for asthma)_____ phone_____

May we call the doctor listed with any questions regarding the child's asthma? Yes No

Please rate the severity of his/her asthma (circle below)

(not severe) 0 1 2 3 4 5 6 7 8 9 10 (severe)

Mild	**Moderate**	**Severe**
*intermittent, brief, <1-2x/wk	*exacerbations >1-2 times/wk	*frequent exacerbations
*asthma symptoms at night, < 2x/month	*asthma symptoms at night, > 2x/month	*continuous symptoms
*no asthma symptoms between exacerbations	*symptoms requiring inhaled medication almost daily	*frequent symptoms at night
		*physical activity limited
		*hospitalization for asthma in previous year
		*previous life-threatening exacerbation

What triggers the child's asthma attacks? (please circle all that apply)

illness emotions medications foods weather exercise smoke chemical odors

other _____

What does child do at home to relieve wheezing during an asthma attack?

breathing exercises
rest/relaxation
drinks liquids

takes medication: _____inhaler
_____nebulizer
_____oral medication

other (please describe)_____

Please list the medications the child takes for asthma (everyday and as needed)

Name of Medication	Dose	Frequency
_____	_____	_____
_____	_____	_____

Parental Consent:

In the event of a medical emergency, as determined by the school nurse or other responsible staff member, it is the policy of Tina-Avalon R-II School District to dial 911 immediately to obtain emergency medical services and/or transport to the nearest approved medical facility. The school officials are hereby authorized to take whatever action is deemed necessary in their judgment, for the health of this child. I will not hold the school district financially responsible for the emergency care and/or transportation of this child.

My signature below verifies the above information to be accurate. I also permit the school nurse to share information with school staff as deemed appropriate by the nurse, to provide for this child's health and safety.

_____ _____

Signature of Parent/Guardian Date Revised 06/2013