HEALTH ASSESSMENT RECORD

SCHOOL YEAR: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GRADE: \_\_\_\_­­­\_\_\_\_\_\_\_\_\_

STUDENT’S NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CIRCLE: M/F

PARENT/GUARDIAN #1 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Best Daytime Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PARENT/GUARDIAN #2 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Best Daytime Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact if parent/guardian are unavailable

Contact #3\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Best Daytime Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact #4\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Best Daytime Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dentist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Specialist? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child have dental and health insurance? \_\_\_\_YES \_\_\_\_NO

If no, would you like information about finding coverage? \_\_\_\_YES \_\_\_\_NO

HEALTH HISTORY: Please indicate if your child has experienced any of the following by circling the item. Conditions that have (!) listed next to them require you to explain the response on the lines listed below AND contact your school’s nurse ASAP.

Fainting/blacking out Back or neck injuries Wears glasses/contacts Chronic nose bleeds

Past concussions Wears hearing aids (!)Asthma (!)Seizures

(!)Diabetes (!)Allergy to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(!)EpiPen prescribed Frequent Strep Throat (!)Cardiac Condition

Daily medication taken at home? If YES, please list name, dosage, and frequency\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(!)Prescription medication needed during the school day? If YES, please list name, dosage, frequency AND contact your school’s nurse asap.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MEDICATION CANNOT BE ADMINISTERED, USED, OR CARRIED BY THE STUDENT WITHOUT WRITTEN CONSENT FROM BOTH THE PARENT/GUARDIAN AND A HEALTH CARE PROVIDER.

If your child has a different health issue not listed above, please provide any needed information here: \_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

STUDENT’S NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

A 504 plan will be considered for any child that has a medical diagnosis and will be updated yearly. Team members may include: parents, classroom teacher, nurse, guidance counselor, provider, and the child, when appropriate.

OVER-THE-COUNTER MEDICATIONS: All medications given by the school nurse requires written consent from a parent/guardian. Below are the OTC medications that we have available in the Health Office. Please do not add medications to the list. If it isn’t listed, it isn’t stocked.

Please circle the medication(s) that you want your child to be offered in the event of illness or injury.

Advil (Ibuprofen)

Bacitracin (antibiotic ointment)

Benadryl (Diphenhydramine)

Burn Gel

Caladryl lotion

Cough drops/Throat Lozenge

Insect Sting Swab

Lip Balm/Vaseline

Tums

Tylenol (Acetaminophen)

CONSENTS: Please read and initial each statement and then sign the form.

\*\* I give consent for the above indicated medications to be given as instructed on the label. To the best of my knowledge, my child has no allergy to the selected medications. I agree to hold harmless SAU63 School District for any side effects which may occur as a result of taking the above indicated medications. INITIALS\_\_\_\_\_\_\_\_\_\_

\*\* I give my child’s primary care provider and/or specialist permission to share information with the school nurse including but not limited to diagnosis, treatment plan, and medication administration. INITIALS\_\_\_\_\_\_\_\_\_\_

\*\* I give the nurse permission to inform SAU63 employees in direct contact with my child of their health issues on a need to know basis if it impacts their safety. INITIALS\_\_\_\_\_\_\_\_\_\_\_

\*\* In case of accident or a serious illness, I understand that the school will try to contact me first. If the school is unable to reach me or if the illness becomes acute, I understand that my child will be transported by ambulance, if necessary. I understand that a fee may be involved. I give permission for SAU63 employees to provide general First Aid. I give permission for EMS to stabilize, transport, and evaluate my child’s condition until a parent can be reached or his/her primary care provider can direct further care. INITIALS\_\_\_\_\_\_\_\_\_\_

PARENT/GUARDIAN SIGNATURE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE\_\_\_\_\_\_\_\_\_\_\_\_