HARRISBURG SCHOOL DISTRICT 41-2

ANNUAL HEALTH RECORD 2017-2018

Student's Name: _____ Birth Date: ____/____/____ M ☐ F ☐

School: _____ Grade:_____ Teacher:_____ Rides Bus: Yes ☐ No ☐

Mother's Name: _____ Phone: H)_____ C)_____ W)_____

Email: _____ Employer/Occupation: _____

Father's Name: _____ Phone: H)_____ C)_____ W)_____

Email: _____ Employer/Occupation: _____

Child lives with: _____ Hospital Preference: _____

Sibling's Names and Ages: _____

Physician's Name: _____ Phone: _____

Emergency Contact: _____ Phone:_____

HEALTH CONDITIONS (check those that apply)

***Bold** items will need to have additional forms completed by physician. Please talk with your school nurse.*

☐ADD/ADHD
☐**Allergies ____Food ____Medication ____Other**
☐**Asthma**
☐Bone/Muscle/Joint Problems
☐Bowel/Bladder Problems
☐**Cardiovascular (Heart/High or Low Blood Pressure)**
☐**Celiac**
☐Other (Please List)_____

☐**Diabetes**
☐G.I. Disorder (Stomach/Intestinal)
☐Hearing Impaired Hearing Aid ___Yes ___No
☐Headache/Migraines
☐Head Injury Date:_____
☐**Seizure Disorder**
☐Visually Impaired Glasses ___Yes ___No

Please explain any answers checked above: (*Additional paperwork may be required)*

_____
_____
_____
_____
_____

Do any health and/or medical conditions require school restrictions, modifications and/or intervention?

☐ YES ☐ NO If YES, please explain:

_____

Does the student require any special procedures and/or treatments for their health condition?

☐ YES ☐ NO If YES, please explain:

_____

Please list any prescription and over the counter medication that your child will need during school day.

MEDICATION	TIME	REASON

Children K-5 are not permitted to carry and self-administer ANY medications, including cough drops. Exceptions are made for Asthma and Anaphylactic medications. Medication maybe administered from the Health Office with proper Medication Administration Forms. Forms must be completed by parent/guardian and all medications delivered to the school by the parents. Medications must also be in original containers.

Middle School and High School

☐ YES ☐ NO I authorize my 6-12th grade student to carry and self- administer OTC medication.

☐ YES ☐ NO I understand that no more than (1) days worth of medication may be carried with the student.

Medication may still be administered by trained staff, as long as the Medication Authorization form is completed and signed by parents.
**Students are prohibited from transferring, delivering or receiving any medications to or from another student.*
**All violations will result in confiscation of the medication and subject to discipline in accordance with the district's policy.*
**Students who use medication for purpose other than for its intended use will be disciplined and will no longer be allowed to carry and self-administer medications.*

This information will become part of your child's confidential permanent record. If for any reason you do not wish to respond to part(s) of this form you are under no obligation to do so. Please understand that we are not responsible for injury or illness that may be a result of these omissions.

By signing below I understand that I am giving my permission to share this information with school staff and trained personnel as needed with strict confidentiality maintained by all.

Parent/Guardian Signature:_____ Date:_____

Office use only

Reviewing Nurse Signature: _____ Date:_____

☐ Individual Health Care Plan ☐ Special Diet Request Form
☐ Medication and Treatment Authorization Form ☐ Other_____

Staff Notified: ☐ Teacher ☐Bus Driver ☐Nutritional Service
☐SPED ☐Principal ☐ Nursing Supervisor