ANNUAL STUDENT HEALTH INFORMATION 2011-2012

(to be completed by parent/guardian)

STUDENT NAME: ______________________ **DATE OF BIRTH:** ____________ **GRADE:** _________

PLEASE CHECK ANY OF THE FOLLOWING CONDITIONS THAT AFFECT YOUR CHILD:

YES	NO	
☐	☐	ADHD
☐	☐	Allergies (please specify)
		Animal________________
		Environmental________________
		Food________________
		________________
		Drug Allergy________________
		Treatment for Reaction________________
☐	☐	Anxiety
☐	☐	Asthma
☐	☐	Autism/Aspergers Spectrum
☐	☐	Cancer
☐	☐	Depression
☐	☐	Diabetes
☐	☐	Hearing concerns

YES	NO	
☐	☐	Stomach/Bowels
☐	☐	Migraines
☐	☐	Heart/Lung
☐	☐	Kidney/Bladder
☐	☐	Orthopedic
☐	☐	Seizures
☐	☐	Vision -contacts / glasses / other
		________________
☐	☐	Other

Please give specifics for any of the above marked YES:

____

____

History of surgeries, major illness or injury: ______________

____

Currently taking any medication on a regular basis (prescription or over the counter)? Yes No

List name, dose, times and reason for taking. ____

____

Medical/Nursing care needed at school (describe in detail). ____

Please note that health concerns such as diabetes, seizures, asthma, and severe allergic reactions will need additional health care plans. Please contact your school nurse as soon as possible to schedule an appointment to complete this information.

Dentist's name ________________________________ phone# ________________

Physician's name ________________________________ phone# ________________

Specialist's name ________________________________ phone# ________________

To ensure the care of my child, I read and agree that pertinent health information may be provided to appropriate school staff. I agree to alert the school nurse of any change in medication and/or health status of my child. I will furnish the school with a current telephone number and address in case of emergency.

EMERGENCY AUTHORIZATION:

I agree that in an emergency, any Rockwood representative may transport or authorize the transportation of my child to a hospital/medical facility and I authorize any physician or other medical personnel to carry out any diagnostic procedures or emergency care deemed necessary. I prefer my child be taken to ___________ hospital. I understand that the cost of medical attention and ambulance are my responsibility. I acknowledge that the foregoing above information is true and correct.

____ ____________________

SIGNATURE OF PARENT *(Legal Guardian if child is in custody of anyone other than parent)* DATE