East Buchanan C-1 School District – Student Health Inventory & Consent

Name:_____ **Birth Date:**_____

(Last) (First) (MI)

Gender: M F **Grade/Teacher**:_____

Does your child have Health Insurance? Yes No **Does your child have Dental Insurance?** Yes No

Physician Name:_____ **Date of last physical exam?**_____

Hospital Preference:_____

Medical Diagnosis by Physician: (Check all that apply) **MUST BE UPDATED EACH SCHOOL YEAR**

☐ Allergy ☐ Food (list below) ☐ Environmental ☐ Insect ☐ Latex ☐ Medication (list below) * ☐ EpiPen ☐ Benadryl ☐ Arthritis ☐ Autism Spectrum Disorder ☐ Autoimmune Disorder _____ ☐ Bowel/Bladder Problem Cancer_____ ☐ Chronic Pain Location_____ _____ ☐ Diabetes ☐ Type I ☐ Type II ☐ Pump ☐ Pen ☐ Syringe ☐ Pill ☐ Developmental Disorder Down's Syndrome Other_____	☐ Ear/Nose/Throat Disorder _____ ☐ Gastrointestinal Disorder ☐ Constipation _____ ☐ Genetic Disorder _____ ☐ Hearing Impairment ☐ Hearing Aide(s) ☐ Cochlear Implant(s) ☐ Heart Condition _____ ☐ Hemophilia Other bleeding disorder_____ ___ ☐ History of Head Injury Number of Concussions___ ☐ Kidney Disorder _____ ☐ Headaches ☐ Migraine ☐ Cluster ☐ Musculoskeletal Disorder _____	☐ Psychological Disorder ☐ ADHD/ADD (circle) ☐ Anxiety ☐ Behavioral ☐ Bipolar ☐ Depression ☐ Mood Disorder ☐ OCD ☐ Psychosis Other_____ ☐ Neurological Disorder ☐ Cerebral Palsy ☐ Hydrocephalus ☐ Seizure Disorder ☐ Diastat ☐ Clonazepam ☐ Spina Bifida ☐ Other_____ ☐ Oral/Dental Disorder _____ ☐ Respiratory Disorder ☐ Asthma Last event_____ ☐ Cystic Fibrosis	☐ Thyroid Disorder ☐ Hypothyroidism ☐ Hyperthyroidism ☐ Visual Impairment ☐ Contacts ☐ Glasses ☐ Other:_____ Any assistive devices utilized: ☐ Wheelchair ☐ Crutches ☐ Scooter ☐ Prosthetic device Other pertinent information that may affect your child throughout the school day:_____ _____ _____ _____ _____ _____ _____ _____

Is student on long term medication? If so, will this need to be administered during school hours?
Explain_____

_____

(A medication administration form must be completed for in-school administration)

Allergies to *food or medication(s)_____

_____

Do you have any concerns about your child's health?_____

_____

I give my permission for the school nurse to share information concerning my child's health with my child's teacher(s) as needed to provide the best possible care when necessary. I give my permission for EB C-1 schools to contact the emergency contacts in student's file in the case of illness or injury. In the event that myself or emergency contacts cannot be reached in an emergency, I give EB C-1 school officials authorization to take whatever action is deemed necessary in their judgement, for the health of my child. In such an event, I give permission for my child to be transported to the nearest hospital and I authorize the hospital to provide emergency treatment. I will assume full responsibility for all charges related to the above. In the event of an emergency, I give permission for release of information on this form to provide health care for my child. *I also give permission for my child to receive over-the-counter medication (Neosporin, Hydrocortisone cream, Tylenol, Ibuprofen, cough drop, Antacid, Anbesol, calamine lotion) and first aid as listed in the East Buchanan C-1 standing orders. I understand all medication will be given according to package instructions.*

Parent Signature: _____ **Date:** _____