Douglas County School District

HEALTH INFORMATION – 2014–2015 (NEW students)

This information will be reviewed and maintained in confidential manner by the School Nurse assigned to your student's school.

STUDENT NAME: _____ **BIRTH DATE:** _____
First Middle Last

SCHOOL: _____ **GRADE / TRACK:** _____

EARLY CHILDHOOD HEALTH HISTORY

Were there any significant problems during the pregnancy, labor or delivery? No ☐ Yes ☐

If yes, please explain? _____

_____

PLEASE CHECK ALL HEALTH CONDITIONS THAT APPLY TO YOUR STUDENT. IF A HEALTH CONDITION PERTAINING TO YOUR STUDENT HAS A COMMENT FIELD, PLEASE PROVIDE ADDITIONAL INFORMATION IN THE FIELD.

Allergies – Life Threatening – Comment required

- ☐ Life threatening allergy – Dairy — **Comment**: _____
- ☐ Life threatening allergy – Food — **List Food(s)**: _____
- ☐ Life threatening allergy – Insect Sting — **Comment**: _____
- ☐ Life threatening allergy – Latex — **Comment**: _____
- ☐ Life threatening allergy – Peanut — **Comment**: _____
- ☐ Life threatening allergy – Tree Nuts — **Comment**: _____
- ☐ Life threatening allergy – Other — **List**: _____
- ☐ Life threatening allergy – Unknown — **Comment**: _____

Allergies – Comment required where indicated

- ☐ Animal
- ☐ Environmental/Seasonal
- ☐ Food — **List Food(s)**: _____
- ☐ Insect Sting
- ☐ Latex
- ☐ Medication — **List Medication(s)**: _____
- ☐ Non-Specific

Other Conditions – Comment required where indicated

- ☐ ADD/ADHD – Name of medication: _____
- ☐ Alopecia
- ☐ Arthritis Juvenile
- ☐ Asthma — **Comment**: _____
- ☐ Autism Spectrum — **Comment**: _____
- ☐ Auto-Immune Condition — **Comment**: _____
- ☐ Blood Disorder — **Comment**: _____
- ☐ Cancer — **Comment**: _____
- ☐ Celiac Disease

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- ☐ Cerebral Palsy
- ☐ Chromosomal Anomalies — **Comment**:_____
- ☐ Crohn's Disease
- ☐ Cystic Fibrosis
- ☐ Diabetes — **Comment**:_____
- ☐ Down Syndrome
- ☐ Emotional Condition — **Comment**:_____
- ☐ Encopresis — **Comment**:_____
- ☐ Enuresis — **Comment**:_____
- ☐ Fetal Alcohol Syndrome
- ☐ Frequent Headaches — **Comment**:_____
- ☐ Gastrointestinal Disorder — **Comment**:_____
- ☐ Head Injury/Concussion — **Comment**:_____
- ☐ Hearing Impaired — **Comment**:_____
- ☐ Heart Condition – No Restriction — **Comment**:_____
- ☐ Heart Condition – Restrictions — **Comment**:_____
- ☐ Hepatitis B Carrier
- ☐ Hepatitis C Carrier
- ☐ History of Injuries — **Comment**:_____
- ☐ Hypoglycemia — **Comment**:_____
- ☐ Immune Compromised — **Comment**:_____
- ☐ Kidney Problem — **Comment**:_____
- ☐ Lactose Intolerant
- ☐ Long QT Syndrome
- ☐ Migraine Headaches
- ☐ Myalgia Myositis Fibromyalgia — **Comment**:_____
- ☐ Neurologic Disorder — **Comment**:_____
- ☐ Nosebleeds
- ☐ Orthopedic – Physical Limitation — **Comment**:_____
- ☐ Orthopedic – No Restrictions — **Comment**:_____
- ☐ Other — **List**:_____
- ☐ Paraplegia
- ☐ Quadriplegia
- ☐ Scoliosis
- ☐ Seizure Disorder — **Comment**:_____
- ☐ Shunt/Hydrocephalus — **Comment**:_____
- ☐ Skin Condition — **Comment**:_____
- ☐ Syncopal Episodes — **Comment**:_____
- ☐ Syndrome — **Comment**:_____
- ☐ Thyroid Condition
- ☐ Tourette Syndrome — **Comment**:_____
- ☐ Tracheostomy — **Comment**:_____
- ☐ Traumatic Brain Injury — **Comment**:_____
- ☐ Urinary Problem — **Comment**:_____

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☐ Wears Glasses/Contacts
☐ Vision Impaired **Comment**:_____
☐ Von Willebrand's Disease
☐ Wolff Parkinson White Syndrome

ADDITIONAL INFORMATION

- List any illness, hospitalization, surgery, accidents your student had in the past year. **None** ☐
  _____ **Date:** _____
  _____ **Date:** _____
  _____ **Date:** _____
- List any emotional, social or other conditions that might affect your student's school performance.
  _____ **None** ☐
- Is your student *currently* taking any medication, including over-the-counter medication? **No**☐ **Yes**☐
  _____
- If your student will need to be given medication at school, a separate Medication Release Form for each medication will be needed. If your student is a middle school student and will self-carry prescription medication, a Permission to Carry Form must be completed for each medication. High school students may self-carry and self-administer one-day supply of medication, carried in a pharmacy labeled container.
- Is your student currently receiving alternative therapies (acupuncture, homeopathic, herbal, biofeedback, etc)? **No** ☐ **Yes** ☐

  If yes, please explain: _____
- **Is there anything else you would like us to know about your student?** **No** ☐ **Yes** ☐
  _____

Parent/Guardian Name (please print)_____

Parent/Guardian Signature_____ **Date** _____