2014 - 2015

CANBY ELEMENTARY SCHOOL ANNUAL HEALTH FORM

Student Name: _____ Birth Date: _____
LAST FIRST MI

☐Male ☐Female Grade: PreK K 1 2 3 4 5 6 Teacher:_____

Dear Parent/Guardian:
A student's health may affect his/her learning. Therefore, health information is important in planning for the student's needs at school. Please complete this form and return it to school as soon as possible.

Parent/Guardian: _____ Phone number: _____cell home work
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Emergency Names: Persons authorized for student when ill or can act in an emergency when parents are unavailable.
Name: _____ Phone:_____ Phone:_____
Name: _____ Phone:_____ Phone:_____

HEALTH CONCERNS:
Please put an (x) if the student has any of these concerns:

☐ **NO HEALTH CONCERNS**

☐ **ADHD/ADD** Diagnosed by Provider: Name _____
Medication (name/dose/time): _____

☐ **Allergies**: ☐Food ☐Medications ☐Bee Stings ☐Seasonal ☐Other: _____
Describe: _____
Life Threatening: ☐ Yes ☐No Epi Pen: ☐Yes ☐No Available in school: ☐Yes ☐No
Medication: _____

☐ **Asthma** or other breathing problems: _____

1. Has student ever been diagnosed by a medical provider as having asthma? ☐Yes ☐No
2. Does student take medication for asthma? (If yes, please list on back of form) ☐Yes ☐No
3. Has the student had episode(s) of wheezing (whistling in the chest) in the last 12 months? ☐Yes ☐No
4. In the last 12 months, have you heard the student wheeze or cough after active playing? ☐Yes ☐No
5. Other breathing problems – Describe: ☐Yes ☐No

_____

☐ **Bladder/Bowel** (constipation) problems (describe): _____
☐ **Chickenpox** – List month/year student had disease: _____
☐ **Diabetes**: ☐Type 1 ☐Type 2 Managed by: ☐Diet only ☐Oral meds ☐Insulin injections ☐Insulin Pump
Additional Information: _____
☐ **Exposure** to drugs and/or alcohol before birth: _____
☐**Health Problems** (describe): _____
☐ **Seizures**: Type (describe): _____
Date of last seizure: _____
☐**Social/Emotional/Behavioral/Mental** health concerns: _____
☐ Anxiety ☐ Depression ☐Social phobia ☐Panic attacks ☐Other: _____
☐Other health concerns or significant history of problems (describe): _____

_____

☐ **Activity Restrictions** (describe): _____
☐ Recent **surgeries** or hospitalizations: _____
☐ Has your child received any **immunizations** in the last year that have not already been reported to school: ☐Yes ☐No
Type of Immunization: _____ Date: _____
Name of Clinic: _____

PLEASE COMPLETE BACK SIDE OF FORM

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MEDICATIONS –

List **ALL** medications that the student takes every day or when needed. Consent is **REQUIRED** for **ALL** medications taken at school, including over the counter medications. **The consent must be signed by both the HEALTH CARE PROVIDER and a PARENT. A NEW CONSENT IS NEEDED EACH SCHOOL YEAR.** Forms are available in the health office or online.

MEDICATION NAME	DOSE	HOW OFTEN/TIME	REASON FOR TAKING

VISION

- ☐ **No Vision problems**
  - ☐ Glasses/contacts prescribed
  - ☐ Wears glasses/contact all of the time
  - ☐ Wears glasses in the classroom only
  - ☐ Glasses lost/broken
  - ☐ Has (or had) glasses but does not wear them

HEARING

- ☐ **No hearing problems**
  - ☐ Frequent ear infections (more than 3/year)
  - ☐ Has ear tube(s) – Date inserted _____
  - ☐ Hearing loss ☐ Left Ear ☐ Right Ear
  - ☐ Hearing aid(s) ☐ Left Ear ☐ Right Ear
  - ☐ Hearing aids lost/broken
  - ☐ Has (or had) aids but does not wear them

Other vision/hearing problems: _____

Any Additional comments:

_____

_____

_____

_____

_____

_____

_____

_____

_____

This health information may be shared with other Canby Elementary school staff on an as needed basis. If you do not want this health information shared, please contact the school nurse.

Parent/Guardian signature: _____ Date: _____

Print Parent/Guardian name: _____

Parent/Guardian e-mail contact (optional): _____