Revised 1/2020

CLINTON PRAIRIE SCHOOL CORPORATION
Student Health Information 2020-2021

Student's Name _____ Grade and Homeroom Teacher _____

I. Health History – Please check if positive: ☐ **None**

	Seizure Condition		Heart Condition		Vision Problems		Hearing Problems
	Asthma		SEVERE Headaches		Glasses for Reading		Frequent Nosebleeds
	Earaches		Seasonal Allergies		Glasses at all times		Fainting Spells
	Diabetes		Other Serious Allergy*		Contacts		MRSA
	ADD/ADHD		Emotional Difficulties		Speech Difficulty		Crohn's/IBS

Give a brief history of any items checked above or other condition: _____

_____

_____

II.*Check Any Severe or Serious Allergy Your Student Has: ☐ **None**

	A. Insect stings (list type)
	B. Food (list type)
	C. Animals (list type)
	D. Other (list)

Indicate the Signs That Are Usually Present During Allergy Attack – *place letter(s) of the allergies checked above, beside the signs*:

	Difficulty breathing		Rash
	Difficulty swallowing		Nausea
	Loss of consciousness		Flushed or unusually pale skin color
	Swelling How much? _____ Where?_____		Other:_____ _____ _____

Has emergency medical treatment been needed in the past year for allergies? No _____ Yes (when) _____

III. Medications Currently Taking ☐ **None**

	Medication and Dosage/Strength	Reason	Amount Taken	Time of Day
A.				
B.				
C.				
D.				

Circle the Letter of any medications to be taken at school; Parent/Guardian to bring to school. Attach a doctor's order.

Please Advise the School Nurse Immediately of Changes in Dose and/or Type of Medication

(If your child has a Special Health Care Need that requires a more extensive plan of care, contact the School Nurse for an appointment.)

IV. Consent (Initial each statement Yes or No)

_____**Yes** _____ **No** I, the parent or guardian of the above named student, give permission to share this information as medically necessary with appropriate personnel and for the school nurse and designated school personnel to provide minor medical care as needed.

_____**Yes** _____ **No** In the event that an emergency arises during school or a school activity, an effort will be made to contact the parents or guardians as soon as possible. If the parents or guardians cannot be reached, permission is hereby granted to the attending physician to proceed with any emergency medical or minor surgical treatments, and/or x-ray examinations for this student. In the event of serious illness, significant injury, or the need for major surgery, the attending physician will attempt to contact the parents or relatives. If the physician is not able to communicate with the parents or relatives, the treatment necessary for the interest of this student may be given. Permission is given to the school to provide needed emergency treatment to the student prior to admission to a medical facility.

_____**Yes** _____ **No** I, the parent or guardian of above named student, give permission for the School Nurse or designated school staff/trainer of Clinton Prairie to give Acetaminophen (generic for Tylenol) or Ibuprofen to my child in the event of headache, menstrual cramps, or minor aches and pain. (No medication will be given to students until this consent is signed and returned.)

V. Emergency Numbers (Starting with Parents/Guardian, Other Adults and Including Doctor-backup for computer failure. This is our backup for Field Trips and/or Computer Failure – Please Complete each year.)

	Name	Relationship	Home	Cell	Work
1.					
2.					
3.					
4.					
5.					

Parent/Guardian Signature _____ **Date** _____