

SCHOOL DISTRICT OF NIAGARA STUDENT HEALTH INFORMATION 2015 – 2016

The following health information is confidential, but pertinent health information may be shared with school staff on a need-to-know basis to provide the best care for your child. If you do not want health information shared, you must provide a written request.

STUDENT NAME: _____ GRADE: _____

Please see the school nurse for any items marked “yes” in the following questions 1-5.

1. ALLERGIES

_____ **YES** **FOOD: What type of food?** _____

Medication needed to treat reaction at school? **Yes** _____ (CALL/SEE NURSE) **No** _____

Type of Medication: EPI-PEN _____ Antihistamine _____ Other _____

_____ **YES** **Bee/Wasp Sting:**

Medication needed to treat reaction at school? **Yes** _____ (CALL/SEE NURSE) **No** _____

Type of Medication: EPI-PEN _____ Antihistamine _____ Other _____

_____ **YES** **Other Allergies:** Please List: _____

Medication needed at school for symptoms? **Yes** _____ (CALL/SEE NURSE) **No** _____

2. ASTHMA

_____ **YES** Asthma triggers: _____

Medication needed to treat symptoms at school? **Yes** _____ (CALL/SEE NURSE) **No** _____

Inhaler _____ Nebulizer _____ Other _____

3. DIABETES

_____ **YES** **Call/See Nurse**
Medication taken at school: Insulin _____ Oral _____

4. SEIZURE DISORDER

_____ **YES** **Call/See Nurse**
Medication taken at school: _____

5. Does your child have any other health conditions/concerns the school should be aware of?

_____ **YES** _____ **NO** If yes, please list medical condition or health/other concerns:

Please list routine daily medications your child will need to take during the school day:

Medication _____ Time _____ (Contact the school nurse)

Does your child wear: Glasses? _____ Contacts? _____

I give my child permission to participate in hearing/vision screening: Yes _____ No _____

Any other information you feel would be helpful to school personnel in caring for your child at school:

If emergency care is required, and no one can be reached, may the school authorities use their judgment in caring for your child? Yes _____ No _____ If no, indicate plan to follow: _____

Your signature gives the school personnel and hospital permission to provide first aid/other medical/emergency care, and is intended for use throughout this school year. Please notify the school personnel of any changes by calling 715-251-4541.

Parent/Guardian Signature

Date