Copy on green

DeSoto ISD
Annual Student Health Information Form
2014/15

Date: _____ Grade: _____ Date of birth: _____

Student Name: _____ Gender (circle) M F

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Dear Parent/Guardian:
In an effort to provide safe, informed care for your child at school, the DeSoto ISD Health Services Department requires updated health information as part of student enrollment. DeSoto ISD keeps all medical information about your child confidential as required by the Family Educational Rights and Privacy Act and other applicable laws. However, the information will enable the school nurse and staff to have a better understanding of the health status of your child. **If your child has an acute or chronic medical condition, or any medical changes occur during the school year, it is your responsibility as the parent/guardian to notify the school nurse and update this information.**

ABDOMINAL ISSUES: Due to: __Irritable bowel syndrome __Gastric reflux __Crohn's disease __Ulcerative colitis __Constipation __Other:_____ What medications are taken for this?_____	**DIABETES:** __Type 1 __Type 2 What medications are taken for this? _____
ADD/ADHD: When was your child diagnosed? _____ Is your child under medical care at this time? Yes / No What medications are taken for this?_____	**EARS, EYES, NOSE:** __Frequent ear infections __Hearing Loss R/L Wears hearing aid? Yes No __Frequent nosebleeds caused by:_____ __Wears glasses or contacts Yes No __Vision loss not corrected with glasses/contacts R/L
ALLERGY: (other than seasonal allergies) __Food allergy (specify food):_____ __Medication allergy (specify med):_____ __Insect allergy (specify insect):_____ __Latex allergy Symptoms of reaction?_____ Has a physician prescribed epinephrine for this allergy? Yes No (if yes, please contact school nurse) What medications are taken for this?_____	**EMOTIONAL ISSUES:** __Depression __OCD __Bipolar __School phobia __Other _____ When was your child diagnosed?_____ Is your child under medical care at this time? Yes No What medications are taken for this?_____
BLOOD DISORDERS: __Sickle cell anemia __Sickle cell trait __Clotting disorder (i.e. hemophilia) __Other_____ What medications are taken for this?_____	**HEART CONDITIONS:** __Long Q/T syndrome __High blood pressure __Irregular heart rate __Heart defect, type:_____ Repaired? Yes No __Other_____ What medications are taken for this?_____
BREATHING ISSUES: __Asthma __Cystic Fibrosis __Tracheotomy __Other_____ When was your child diagnosed?_____ Is your child under medical care at this time? Yes No What medications are taken for this?_____ How often does your child use rescue inhaler?_____ Does your child use a nebulizer? Yes No Does your child wake at night with a cough? Yes No	**MUSCLE, BONE, JOINT DISORDERS:** __Arthritis __Scoliosis __Other:_____ Are there any P.E. restrictions for this condition? Yes No Is your child under medical care at this time? Yes No What medications are taken for this? _____
COMMUNICABLE DISEASES: Has your child has chicken pox? Yes No Date:_____ Has your child has a positive TB test? Yes No Date:_____	**OTHER HEALTH CONDITIONS:** _____ _____ **Special procedures:** (tube feeding, catheterization, etc) _____

All medications taken during school hours and school related activities must be brought to the clinic. A separate permission form is required for each medication. Texas law requires parent and physician permission to carry an inhaler or emergency epinephrine at school. Contact your school nurse for information.

☐ **My child has NO KNOWN HEALTH CONDITIONS and does not require any medications at home or school.**

Parent/Guardian Signature_____ Date_____

Parent/Guardian Name (Print)_____