



## Acalanes Union High School District Health Information

Please fill out this form upon your student's enrollment in the district OR if there are changes in his/her health status.

**THE STUDENT MUST HAVE CURRENT IMMUNIZATION DATES ON FILE WITH THE SCHOOL NURSE. BE SURE IMMUNIZATION INFORMATION IS SUBMITTED TOGETHER WITH THIS FORM OR IS CURRENTLY ON FILE**

In order to provide the best learning experience for the student, it is important that we have an understanding of the student's health status. Please complete this form and it will be given to the School Nurse. Please contact your School Nurse to discuss any health problem in more detail.

Date: \_\_\_\_\_ Student's Name: \_\_\_\_\_  
(Last) (First) (Middle)

School: \_\_\_\_\_ Grade: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Class of: \_\_\_\_\_

### Please check the appropriate boxes.

- |  |  |
|--|--|
| <input type="checkbox"/> Allergy, non-life threatening type: _____                   | <input type="checkbox"/> Growth disorder   |
| <input type="checkbox"/> Allergy, life threatening (list type/medication* next page) | <input type="checkbox"/> Gynecological problems (explain on next page)                                   |
| <input type="checkbox"/> Anxiety (list medication* on next page)                     | <input type="checkbox"/> Headache-severe   |
| <input type="checkbox"/> Auditory Processing Problem                                 | <input type="checkbox"/> Hearing loss (which ear <input type="checkbox"/> L <input type="checkbox"/> R ) |
| <input type="checkbox"/> Depression (list medication* on next page)                  | <input type="checkbox"/> Hearing aid (which ear <input type="checkbox"/> L <input type="checkbox"/> R )  |
| <input type="checkbox"/> Arthritis   | <input type="checkbox"/> Heart Condition   |
| <input type="checkbox"/> Asthma-mild   | <input type="checkbox"/> Immune system disorder  |
| <input type="checkbox"/> Asthma-severe (list medication* on next page)               | <input type="checkbox"/> Infectious disease (explain on next page)                                       |
| <input type="checkbox"/> ADD (list medication* on next page)                         | <input type="checkbox"/> Kidney/urinary disorder   |
| <input type="checkbox"/> ADHD (list medication* on next page)                        | <input type="checkbox"/> Medication prescribed * (list on next page)                                     |
| <input type="checkbox"/> Bee sting-medication required (list medication* on next p.) | <input type="checkbox"/> Medication required at school * (list on next page)                             |
| <input type="checkbox"/> Genetic disorder (explain on next page)                     | <input type="checkbox"/> Menstrual problems - severe   |
| <input type="checkbox"/> Blood disorder/Hemophilia                                   | <input type="checkbox"/> Migraine (list medication* on next page)  |
| <input type="checkbox"/> Blood/blood products (check if <u>not</u> to be given)      | <input type="checkbox"/> Nose bleeds – frequent/severe   |
| <input type="checkbox"/> Cancer/Leukemia   | <input type="checkbox"/> Orthopedic/joint disorders  |
| <input type="checkbox"/> Cerebral Palsy  | <input type="checkbox"/> Physical activity limitations **  |
| <input type="checkbox"/> Concussion/head injury (give date/explain on next page)     | <input type="checkbox"/> History of serious injury (explain on next page)                                |
| <input type="checkbox"/> Cystic Fibrosis   | <input type="checkbox"/> Skin problem  |
| <input type="checkbox"/> Diabetes type: ____ (list medication* on next page)         | <input type="checkbox"/> Speech problem  |
| <input type="checkbox"/> Eating disorder   | <input type="checkbox"/> Surgery (date/explanation on next page)   |
| <input type="checkbox"/> Endocrine disorder  | <input type="checkbox"/> Tourette's syndrome (list medication* on next page)                             |
| <input type="checkbox"/> Epilepsy/seizure disorder (list medication* on next page)   | <input type="checkbox"/> Vision impairment – color vision defect   |
| <input type="checkbox"/> Immunization exemption                                      | <input type="checkbox"/> Vision impairment – glasses/contact lenses                                      |
| <input type="checkbox"/> Fainting  | <input type="checkbox"/> Other (explain on next page)  |
| <input type="checkbox"/> Gastrointestinal disorder type: _____                       | <input type="checkbox"/> No known health problems  |

**\* REQUIRED: Medication Form available from District website and schools. Requires doctor's AND parent's signatures.**

**\*\* Requires doctor's note.**

Can the student participate in a full Physical Education program? ☐ YES ☐ NO (doctor's note required)

The school nurse would usually like to share with the student's teacher(s) health information about the student which may affect his/her school work. Please initial here if you do NOT want information shared: \_\_\_\_\_

### PARENT AUTHORIZATION FOR EXCHANGE OF INFORMATION WITH STUDENT'S PHYSICIAN

I hereby give my consent to the School Nurse to receive from or send any information to

Dr. \_\_\_\_\_ Phone: \_\_\_\_\_ Email: \_\_\_\_\_

concerning my child \_\_\_\_\_ OR to **decline** consent, initial here \_\_\_\_\_

**Required Signature of Parent/Guardian who filled out this form:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Printed Name of Parent or Guardian:** \_\_\_\_\_

**Date:** \_\_\_\_\_ **Student's Name:** \_\_\_\_\_

Please reference the condition and explain or list medications here:

[illegible]

Please download and print any of the following care plans for these significant health conditions and take to your physician to fill out. Return the hardcopy to the School Nurse.

Allergy/anaphylaxis care plan at: <http://www.acalanes.k12.ca.us/AnaphylaxisCarePlan>

**Asthma care plan at: <http://www.acalanes.k12.ca.us/AsthmaCarePlan>**

Diabetes care plan at: <http://www.acalanes.k12.ca.us/DiabeticCarePlan>

Seizure care plan at: <http://www.acalanes.k12.ca.us/SeizureCarePlan>