

# **Tina-Avalon R-II School Student Health Form**

Student's Full Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_ Male or Female

Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

\_\_\_\_\_ County: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_

Emergency contact numbers: \_\_\_\_\_ cell \_\_\_\_\_ wk

Additional Person to contact in emergency: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_ cell: \_\_\_\_\_

Student's Physician: \_\_\_\_\_ Phone: \_\_\_\_\_ Date of last physical: \_\_\_\_\_

Student's Dentist: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Date of last exam: \_\_\_\_\_ Does child have dental sealants? Yes No

If student is 6 years or under, has he/she been tested for lead? Yes No

Preferred Hospital: \_\_\_\_Hedrick Medical Center 646-1480 or \_\_\_\_Carroll Co. Memorial Hospital 542-1695

## **Health Concerns:**

Child has health concerns: Yes No If yes, please complete the following (circle all that apply):

Eyes: glasses for reading glasses for distance contacts crossed lazy eye

other \_\_\_\_\_

Ears: frequent infections tubes hearing aid other \_\_\_\_\_

Allergies: (medication, food, insects, pollen, latex) please list and explain reaction

Seizures: Yes No cause: \_\_\_\_\_ date of last seizure: \_\_\_\_\_ medication: Yes No

Other: nose bleeds blood disorder blood pressure neurological orthopedic headaches dental skin  
diabetes heart problem lungs bowel bladder menstruation phobias eating sleeping

other \_\_\_\_\_

## **Prescribed Daily Medications:**

Medication \_\_\_\_\_ Dosage \_\_\_\_\_ Time \_\_\_\_\_ Reason \_\_\_\_\_

Medication \_\_\_\_\_ Dosage \_\_\_\_\_ Time \_\_\_\_\_ Reason \_\_\_\_\_

Medication \_\_\_\_\_ Dosage \_\_\_\_\_ Time \_\_\_\_\_ Reason \_\_\_\_\_

**Permission to administer over the counter medication:**

I grant permission for this child to receive the appropriate dosage for his/her age and weight of the following over the counter medication for pain, cough, sore throat, skin irritations, tooth pain, upset stomach, foreign object in eye or fever.

\_\_Tylenol/Acetaminophen \_\_Ibuprofen \_\_Cough drops \_\_ Lip Balm/Vaseline \_\_Natural Tears eye drops \_\_Anti-Itch Cream  
\_\_First Aid/Burn/Antibiotic Ointment \_\_Orajel/Oral Anesthetic \_\_Benadryl for allergies /allergic reaction \_\_ Tums/Antacid

Does the child suffer from asthma?    Yes    No    If answer is yes, please complete the following.

**Asthma Health History:**

How long has the child had asthma? \_\_\_\_\_

How many days would you estimate he/she missed last year due to asthma? \_\_\_\_\_

Name of child’s doctor (for asthma)\_\_\_\_\_ phone\_\_\_\_\_

May we call the doctor listed with any questions regarding the child’s asthma?    Yes    No

Please rate the severity of his/her asthma (circle below)

(not severe) 0    1    2    3    4    5    6    7    8    9    10 (severe)

**Mild**

- \*intermittent, brief, <1-2x/wk
- \*asthma symptoms at night, < 2x/month
- \*no asthma symptoms between exacerbations

**Moderate**

- \*exacerbations >1-2 times/wk
- \*asthma symptoms at night, > 2x/month
- \*symptoms requiring inhaled medication almost daily

**Severe**

- \*frequent exacerbations
- \*continuous symptoms
- \*frequent symptoms at night
- \*physical activity limited
- \*hospitalization for asthma in previous year
- \*previous life-threatening exacerbation

What triggers the child’s asthma attacks? (please circle all that apply)

illness    emotions    medications    foods    weather    exercise    smoke    chemical odors

other \_\_\_\_\_

What does child do at home to relieve wheezing during an asthma attack?

breathing exercises  
rest/relaxation  
drinks liquids

takes medication: \_\_\_\_\_inhaler  
\_\_\_\_\_nebulizer  
\_\_\_\_\_oral medication

other (please describe)\_\_\_\_\_

**Please list the medications the child takes for asthma (everyday and as needed)**

Name of Medication	Dose	Frequency
_____	_____	_____
_____	_____	_____

**Parental Consent:**

In the event of a medical emergency, as determined by the school nurse or other responsible staff member, it is the policy of Tina-Avalon R-II School District to dial 911 immediately to obtain emergency medical services and/or transport to the nearest approved medical facility. The school officials are hereby authorized to take whatever action is deemed necessary in their judgment, for the health of this child. I will not hold the school district financially responsible for the emergency care and/or transportation of this child.

My signature below verifies the above information to be accurate. I also permit the school nurse to share information with school staff as deemed appropriate by the nurse, to provide for this child’s health and safety.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

Revised 06/2013