Amite County Elementary School

**STUDENT HEALTH RECORD FOR SCHOOL NURSE**

School Year 2019-2020

Grade\_\_\_\_\_\_\_\_

(Please complete: Information to be shared with teaching staff as needed.) Male  Female

Student’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_

Father/Mother/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (relationship)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Student’s Medical History**

|  |  |  |  |
| --- | --- | --- | --- |
| **Problem** | **No** | **Yes** | **If yes, list allergies and describe reaction** |
| Allergies to food |  |  |  |
| ….to medication |  |  |  |
| …insect bites or stings |  |  |  |
| ….other(including seasonal) |  |  |  |
| Does student have an Epipen? |  |  |  |
| Asthma |  |  |  |
| Does student use an inhaler? |  |  | **Name of inhaler? How often?** |
| Does student use a nebulizer? |  |  | **Name of medication for nebulizer? How often?** |
| Attention deficit (ADD, ADHD) |  |  | **Please list meds taking for ADD or ADHD**  **Name of Medication:** |
| Birth defect/physical handicap |  |  |  |
| Bladder problems |  |  |  |
| Bone or joint problems |  |  |  |
| Convulsions (seizure/epilepsy) |  |  |  |
| Diabetes (high blood sugar) |  |  |  |
| Earaches (frequent? Tubes? |  |  |  |
| Emotional/Psychological disorder |  |  |  |
| Headaches |  |  |  |
| Heart problems |  |  |  |
| Hypertension (high blood pressure) |  |  |  |
| Nose bleeds |  |  |  |
| Sinus problems |  |  |  |
| Speech and/or Hearing problems |  |  |  |
| Stomach or digestive problems |  |  |  |
| Surgeries |  |  | **List:** |
| Vision (seeing) problems |  |  | **Glasses? \_\_\_\_\_yes \_\_\_\_\_no Contacts? \_\_\_\_yes \_\_\_\_no** |

Describe any handicaps or special needs of student: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is the student taking daily medication? \_\_\_yes \_\_\_no. If yes, please name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any other concerns you feel I should know about your child. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_