

2010-2011
Health History Information
Rochelle Elementary School District #231

Please complete both sides.

The information on this form is confidential.

Teacher & Grade _____

Student Name _____ Birth-date _____

Address _____

Home # _____ Emergency # _____

Work # _____ Any Alternate #'s _____

Parent(s)/Guardian Name(s) _____

Physician / Specialist _____

ASTHMA:

- 1.) Has your child been *diagnosed* with asthma? _____ Date of last attack _____
- 2.) What causes an attack in your child? Allergies ___ infections ___ weather ___ exercise ___
anything not listed: _____
- 3.) Usual symptoms: _____
- 4.) Will your child keep an inhaler in the health office for use during school? ___ yes ___ no ___
(If yes, we need a medication permission form signed by the providing physician. You can obtain this form from the health office.)
- 5.) Best Peak Flow (if known): _____

ALLERGIES (including food):

- 1.) Has your child been *diagnosed* with any kind of allergies? Yes _____ No _____
- 2.) What, *specifically*, causes an allergic reaction in your child? _____

(If food allergies of any kind, please contact your child's health office to further plan for food intake during school hours.)
- 3.) Usual or past reactions? Redness ___ swelling ___ itching ___ hives ___ rash ___
anything not listed: _____
- 4.) Does your child use any medication(s) for symptoms? _____
(If yes, medication must be provided by parent and we will need a medication permission form signed by providing physician.)
- 5.) What actions should be taken if reaction occurs during school: _____
contact parent _____ Call 911 _____ (applies for all epi-pen use)

SEIZURE DISORDER:

- 1.) Type of seizures: _____
- 2.) Age of diagnosis: _____ Average length of seizure _____
- 3.) Date of last seizure _____ Does your child take anti-seizure medication? _____
- 4.) Name of medication(s) taken: _____
(If your child needs anti-seizure medication administered during school hours please contact your student's health office for further information and a medication permission form.)
- 5.) If no medication(s) currently taken, when was last medication date? _____

DIABETES:

- 1.) Which type does your child have? Type I _____ Type II _____
- 2.) Age of diagnosis? _____
- 3.) Does your child use an insulin therapy pump? Yes _____ No _____
What is the brand of pump? _____
- 4.) Does your child use injections? Yes ___ No ___
Is your child comfortable with self injecting? Yes ___ No ___
(Doctors orders and a medication permission form will be needed.)

Please go to 2nd page



HEART CONDITION:

1.) Describe problem: _____

2.) Any restriction(s): _____

(A note from your child's physician or specialist may be required for your child to participate in physical education. Please check with your child's health office.)

3.) Any medication(s): _____

OTHER HEALTH NEEDS OR CONCERNS: (includes ADHD, dental problems, dentures, orthopedic conditions, mental health concerns, etc):

Any medications taken at home that you have not already listed: _____

Any medication(s) that will need to be kept at school: _____

(A medication permission form will need to be signed by providing physician for health office to administer medication to your child. This can be obtained from the health office where your child attends.)

VISION:

Does your child wear glasses? Yes _____ No _____

Does your child wear contacts? Yes _____ No _____

HEARING:

Has your child ever been screened by an audiologist? Yes _____ No _____

Does your child have a hearing impairment? Yes _____ No _____

Does your child wear a hearing device? Yes _____ No _____

Does your child have hearing implants? Yes _____ No _____

Please note:

As the parent, you are primarily responsible for administering medication to your child. However, we are aware that you cannot always do so and may wish to have the school health office personnel administer or supervise your child self-administering medication. To schools, a medication is any drug purchased over the counter (for example, Tylenol, cough syrup), as well as those prescribed by a doctor. Our schools maintain no supply of medications. Medications are to be supplied in an original container; be clearly marked with the students name and correct dosage. At school, medications will be stored in a locked cabinet and accessible only by school personnel. If a student is to have a medication on his/her person, such as an inhaler or epinephrine auto injector; there will need to be a doctors order for this. Requests for medication administration are good for a school year only and must be renewed each school year.

MEDICATION PERMISSION SECTION:

I, the parent / guardian of this student, authorize Rochelle Elementary School District #231 and its employees, in my behalf and stead, to administer or to allow my child to self-administer with supervision lawfully prescribed medication. I acknowledge that it may be necessary for the administration of medications to my child be performed by an individual other than the school nurse and specifically consent to such practice. I further acknowledge and agree that when the lawfully prescribed medication is so administered or attempted to be administered, I waive any claims that I might have against District #231 and its employees, arising out of the administration of said medication. In addition, I agree to hold harmless and indemnify District #231 and its employees, either jointly or severally, from and against any and all claims, damages, causes of action or injuries incurred or resulting from the administration or attempted administration of said medication(s).

Printed Parent/Guardian Name(s)

Parent/Guardian Signature(s)

Date

**Should you have any further questions or requests of the school health office personnel, please do not hesitate to contact your child's attendance center.*

Central 815-562-8251 Lincoln 815-562-4520 May 815-562-6331 RMS 815-562-7997 Tilton 815-562-6665