

STUDENT HEALTH INFORMATION FORM

-THIS FORM MUST BE SUBMITTED TO THE HEALTH OFFICE BEFORE THE STUDENT STARTS SCHOOL EACH YEAR-

**Student Name:** \_\_\_\_\_ **School Year:** \_\_\_\_\_  
(Last Name, First Name)

**School:** \_\_\_\_\_

**Birthdate:** \_\_\_\_\_ **Sex:** F / M **Teacher:** \_\_\_\_\_ **Grade:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Parent/Guardian Name:** \_\_\_\_\_ **Parent/Guardian Name:** \_\_\_\_\_

**Primary Phone:** \_\_\_\_\_ **Primary Phone:** \_\_\_\_\_

**Secondary Phone:** \_\_\_\_\_ **Secondary Phone:** \_\_\_\_\_

**EMAIL:** \_\_\_\_\_ **EMAIL:** \_\_\_\_\_

**Student lives with:** \_\_\_\_\_

> Please explain custody arrangements if applicable: \_\_\_\_\_

**Emergency contact name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Emergency contact name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Please check ☒ the health conditions that your child has NOW:** (describe \*specific details for any checked items below)

- |   |  |
|---|--|
| <input type="checkbox"/> ADD/ADHD   | <input type="checkbox"/> Arthritis/Orthopedic                          |
| <input type="checkbox"/> Allergy to foods: _____  | <input type="checkbox"/> Headaches/Migraines/Past Concussions (circle) |
| <input type="checkbox"/> Your child needs to sit at the nut-free table  | <input type="checkbox"/> Heart** (please specify): _____               |
| <input type="checkbox"/> Anaphylaxis** to what: _____   | <input type="checkbox"/> High Blood Pressure                           |
| <input type="checkbox"/> Your child needs medications** at school to treat a life-threatening allergic reaction | <input type="checkbox"/> Liver   |
| <input type="checkbox"/> Allergy to insect bites  | <input type="checkbox"/> Menstrual Cramps: Mild/Severe (circle)        |
| <input type="checkbox"/> Allergy to Pollen/Seasonal   | <input type="checkbox"/> Psychiatric/Emotional/Depression (circle)     |
| <input type="checkbox"/> Allergy to Medications (please list): _____  | <input type="checkbox"/> Recent Operations/Serious Injuries: _____     |
| <input type="checkbox"/> Asthma**   | <input type="checkbox"/> Recurrent Ear Infections                      |
| <input type="checkbox"/> Diabetes**: Type I/Type II (circle)  | <input type="checkbox"/> Urinary/Kidney                                |
| <input type="checkbox"/> Seizure Disorder**   | <input type="checkbox"/> Other: _____                                  |

\*Specific details: \_\_\_\_\_

**\*\*Please call and make an appointment with the School Nurse (RN) to discuss any SIGNIFICANT health issues**

**MEDICATIONS:**

Medications taken at <b>SCHOOL</b> :	Dosage / Frequency:	Reason:

Medications taken at <b>HOME</b> :	Dosage / Frequency:	Reason:

STUDENT NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ GRADE: \_\_\_\_\_

Does the student have any of the following? (please check all that apply)

☐ Glasses/Contacts (circle)      ☐ Color Vision Deficiency      ☐ Hearing Problems/Aids

Assistive devices: \_\_\_\_\_

**IN CASE OF EMERGENCIES:** Our procedure will be to contact the parent. If we are unable to reach the parent, the seriousness of the problem will dictate the course of action to be taken:

1. The person you designate will be called and may be asked to care for your child.
2. In accordance with district policy, the school nurse, principal, or authorized designee shall call an emergency medical service if it appears hospital treatment may be required. In the event the paramedics are called and emergency transportation is advised, the individual patient shall be responsible for the cost.

Do you give your consent for your child to be taken to the closest hospital by ambulance if necessary, and emergency care be provided in the event you cannot be reached?

Yes / No (circle) Parent/Guardian initial: \_\_\_\_\_

Do you give your consent to share relevant health information regarding your child with appropriate school and/or emergency personnel as necessary? This would include permission for communication between the health provider and school nurse to facilitate this process.

Yes / No (circle) Parent/Guardian initial: \_\_\_\_\_

Doctor's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Hospital Preference: \_\_\_\_\_

PARENT/GUARDIAN SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**PERMISSION FOR OVER-THE-COUNTER MEDICATIONS:**

- > **Acetaminophen** (generic Tylenol): Used to relieve mild to moderate pain from headaches, muscle aches, menstrual periods, colds and sore throats, toothaches, backaches, and reactions to vaccinations (shots), and to reduce fever.
- > **Ibuprofen:** Used to reduce fever and to relieve minor aches and pain from headaches, muscle aches, arthritis, menstrual periods, the common cold, flu, sore throat, toothaches, and backaches.
- > **Tums:** Used to relieve heartburn, acid indigestion, and upset stomach.

Please CIRCLE the appropriate response for the medication you give permission for your child to receive.

YES	NO	<b>Acetaminophen: liquid or 325mg tablets</b> 4-5 years of age: 240mg 6-8 years of age: 320mg 9-10 years of age: 400mg 11 years of age: 325mg to 480mg 12+ years of age: 325mg to 650mg	YES	NO	<b>Ibuprofen: liquid or 200mg tablets</b> 4-5 years of age: 150mg 6-8 years of age: 200mg 9-10 years of age: 250mg 11 years of age: 300mg 12+ years of age: 200mg – 400mg
YES	NO	<b>Cough drops – HIGH SCHOOL ONLY</b>	YES	NO	<b>Antacid chewable tablet:</b> 1-2 tablets by mouth as needed

I hereby authorize the designee of Catalina Foothills School District to be my agent and give the age appropriate dose of the above-named medication(s) to my child. Please do not give the medication(s) to my child that are circled 'NO.'

PARENT/GUARDIAN SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**THIS FORM MUST BE SUBMITTED TO THE HEALTH OFFICE BEFORE THE STUDENT STARTS SCHOOL EACH YEAR**

Notify the Health Office immediately of any changes throughout the year – A NEW FORM MUST BE COMPLETED ANNUALLY