Academy ISD Health Services
Student Information

Grade:_____

PRINT STUDENT'S NAME:	DOB:	☐MALE ☐ FEMALE

COMPLETE ALL BOXES THAT APPLY TO YOUR CHILD

Parent or guardian is responsible for providing the school with any medication, special diet, or equipment that the student will require during the school day. Check the school website or clinic to obtain correct medication and procedural forms. Parent or guardian is responsible for providing the school nurse with any necessary medical information, appropriate authorization forms, and written consent to exchange information with the child's physician. The information below will be secured in the health services clinic and the district's electronic systems. This information will be shared only on a "need to know" basis.

My child has medical, vision and/or hearing conditions that may affect his/her school day: ☐ Yes ☐ No If YES, please complete below.	FOR NURSE USE ONLY
☐ Vision Conditions ☐ Hearing Conditions ☐ Contacts ☐ Hearing aid(s) ☐ Glasses ☐ Other: _____ ☐ Other: _____	☐ Data Entered
ADD/ADHA/Other Behavioral Issue Medication: ☐ At home _____ ☐ At school _____	☐ Data Entered ☐ Standard Med Procedure ☐ No Ongoing Nursing Mgmt. Currently
☐ Asthma ☐ Triggers ☐ Exercise ☐ Environmental ☐ Other _____ Physical Education Restrictions: ☐ None ☐ Self Limits ☐ Other _____ Will the student self-administer inhaler medication? ☐Yes ☐No ☐ In School ☐ At home ☐ Inhalers _____ ☐ Oral _____ ☐ Nebulizer _____	☐ Data Entered ☐ Standard Med Procedure ☐ Emergency Care Plan ☐ RN ☐ No Ongoing Nursing Management Currently
☐ Food Allergy: _____ Is the reaction severe: ☐ Yes ☐ No Describe: ☐ Coughing ☐ Hives ☐ Difficulty Breathing ☐ Wheezing ☐ Generalized swelling ☐ Other _____ Medications: ☐ Oral antihistamine (Benadryl, etc.) ☐ Epi-Pen ☐ In School ☐ At home ☐ Food Substitution required	☐ Data Entered ☐ Diet Order ☐ Standard Med Procedure ☐ Emergency Care Plan ☐ RN ☐ No Ongoing Nursing Mgmt. Currently
☐ Medication Allergy: _____ Is the reaction severe: ☐ Yes ☐ No Describe: ☐ Coughing ☐ Hives ☐ Difficulty Breathing ☐ Wheezing ☐ Generalized swelling ☐ Other _____	☐ Data Entered
☐ Insect or Other Allergy: _____ Is reaction severe: ☐ Yes ☐ No Describe: ☐ Coughing ☐ Hives ☐ Difficulty Breathing ☐ Wheezing ☐ Generalized swelling ☐ Other _____ Medications ☐ Oral antihistamine (Benadryl, etc.) ☐ Epi-Pen ☐ In School ☐ At home	☐ Data Entered ☐ Standard Med Procedure ☐ Emergency Care Plan ☐ RN ☐ No Ongoing Nursing Mgmt. Currently
☐ Diabetes 1 ☐ Diabetes 2 Currently prescribed treatments to be used ☐ In School ☐ At home Oral Medication(s): _____ ☐ Injectable Medications: _____	☐ Data Entered ☐ Standard Med Procedure ☐ Emergency Care Plan ☐ RN ☐ No Ongoing Nursing Mgmt. Currently
☐ Seizures (Type of seizure): ☐ Absence (staring, unresponsive) ☐ Complex partial ☐ Generalized tonic-clonic (grand mall, conclusive) ☐ Other (explain) _____ Date of Last Seizure: _____ Length of seizure: _____ Currently meds to treat seizures: _____ ☐ In School ☐ At home	☐ Data Entered ☐ Standard Med Procedure ☐ Emergency Care Plan ☐ RN ☐ No Ongoing Nursing Mgmt. Currently
☐ Heart Condition (Be specific): _____ PE Restrictions: ☐ Yes ☐ No ☐ Other restrictions: _____	☐ Data Entered ☐ Standard Med Procedure ☐ Emergency Care Plan ☐ RN ☐ No Ongoing Nursing Mgmt. Currently
☐ Kidney/bladder disorder (be specific)	☐ Data Entered ☐ Standard Med Procedure ☐ Emergency Care Plan ☐ RN ☐ No Ongoing Nursing Management Currently
☐ Cancer (be specific) ☐ Blood Disorder (be specific)	
☐ Surgery (please explain)	
☐ Other (please explain)	
☐ Special procedures (e.g. catheterization, cardiac monitor, etc.) Required IN SCHOOL ☐ Yes ☐ No	
☐ My child plans to ride the bus ☐ Yes ☐ No	☐ Transportation Plan ☐ Notified

List phone numbers of those who should be called first when your child is sick or injured. In case of serious accident or illness and no one designated in my emergency contacts can be reached, I authorize the school to arrange for all necessary medical services for said child on my behalf, and I will be responsible for all necessary medical services for said child on my behalf, and I will be responsible for all medical costs incurred.

1. Parent/Guardian:	Phone:
2. Parent/Guardian:	Phone:
3. Emergency Contact Name:	Phone:
4. Emergency Contact Name:	Phone:
Physician Name:	Phone:
Hospital of Choice:	Insurance: ☐ Private ☐ CHIP ☐ Medicaid ☐ None
Parent Signature:	Date:
Nurse Signature:	Date:

PLEASE SEE MEDICAL INFORMATION ON THE BACK PAGE →