HALFWAY R-III SCHOOL DISTRICT ANNUAL 2021-2022 HEALTH HISTORY FORM
PK-6th grade

Your Child's learning depends on good health.

Student's Full Name _____ Birthdate_____ Grade_____ Circle one: M / F
Bus Rider: Y/N (if yes, what bus?) _____

Does this student have health insurance: □ Private □ No Insurance □ Medicaid
Primary Care Physician _____ Dentist _____
Does your child have: Glasses ____ Contacts ___ Braces____ Dental Appliances ___ Hearing Aid ___ Other _____

Is your child allergic to: Medicine _____ Food _____ Other _____
If your child has an allergy, please list the specific allergy, type of reaction, and treatment:

My Child is allergic to: (List allergy below)	Reaction: Treatment:

Does your child require the use of an Epi-Pen or has been prescribed an Epi-Pen? Yes _____ No _____
If yes, please contact the school nurse ASAP. An anaphylaxis plan is required.
*If your child's allergy requires **food** modifications, please ask the nurse for a "special meal form" that is to be completed by the child's medical provider.*

My Child has the following medical concern(s). Please circle / list all that apply:

ADD/ADHD or other behavioral diagnosis: _____
Asthma or other respiratory diagnosis: _____
please list any medication student will have at school to treat asthma / respiratory condition:
_____
Bleeding Disorder: _____
Cardiac (heart) condition: _____
Depression, Anxiety, or other mental health diagnosis: _____
Diabetes (type 1 or 2): _____
Ears / Nose / Throat diagnosis: _____
Vision / Eye problems: _____
Recurrent Headaches / Migraine: _____
Seizures or other neurological diagnosis: _____
Surgery (specify type and date): _____
Other (Please specify): _____

Please list the names and dosages of any medications your child is taking (both prescription and over the counter):
at home _____
at school _____

*To ensure the proper care of my child, I agree that pertinent health information may be shared with appropriate school staff when needed. I agree to alert the school nurse of any change in medication and/or health status of my child. I will provide the school with a current telephone number and address for use in case of emergency. I understand that the health office will provide basic first aid to my child as needed. I agree that my child may be screened for vision, hearing, height, weight, and blood pressure during the school year.

Please initial your consent _____

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*As directed in the Halfway Schools policy, the health office will have emergency Benadryl, Epi-Pen, Asthma rescue medication, and Narcan available for use in a life-threatening emergency including anaphylactic reaction, acute asthmatic episode, or suspected drug overdose. These medications will be administered by the school nurse or trained employee in accordance with written protocols signed by a licensed physician.
Please initial your consent _____

In case of illness and injury, the school nurse will make appropriate assessments and decisions based on sound nursing judgment and may administer the following medications:

If your child has an allergy to any of these or is not allowed to have them, please mark through the line and initial beside it.

- **Acetaminophen (Tylenol)** given as needed (but not more than 4 hours from previous dose) for pain relief and/or fever. Dosing guidelines for administration of Tylenol is based upon weight, not age, and signed by Halfway Schools Approving Physician. **WILL NOT BE GIVEN WITHOUT OBTAINING VERBAL CONSENT FROM PARENT/GUARDIAN PRIOR TO ADMINISTRATION TO VERIFY LAST DOSE (IF GIVEN) AND TO DISCUSS WHEN NEXT DOSE WOULD BE DUE IF NEEDED.**

- **Ibuprofen** given as needed (but not more than 6 hours from previous dose) for pain relief and/or fever. Dosing guidelines for administration of ibuprofen is based upon weight, not age, and signed by Halfway Schools Approving Physician. **WILL NOT BE GIVEN WITHOUT OBTAINING VERBAL CONSENT FROM PARENT/GUARDIAN PRIOR TO ADMINISTRATION TO VERIFY LAST DOSE (IF GIVEN) AND TO DISCUSS WHEN NEXT DOSE WOULD BE DUE IF NEEDED**

- **Cough drops, Throat Lozenges** (neither containing dextromethorphan) **& Peppermints**. May administer 1 cough drop, throat lozenge, or peppermint every 2 hours as needed for cough or sore throat.

- **Lubricant Eye Drops** for relief of burning, irritation, or discomfort due to dryness of eye.

- **Eye Rinse** for removal of suspected foreign body.

- **Orajel** (benzocaine 10% oral suspension) one drop to sore gum/lip area every 6 hours as needed for oral pain.

- **Topical treatments:** aloe vera, antiseptic / analgesic (benzalkonium / lidocaine), triple antibiotic ointment, anti-itch cream (benadryl/diphenhydramine), 1% hydrocortisone cream, calamine lotion, lotion, carmex, vaseline

- **Misc. Topical Prevention:** sunscreen, insect repellant

Best # to reach you:_____, preferred email address: _____

Parent / Guardian name: _____ signature: _____ date: _____

Emergency contact: _____ phone number: _____