

HALFWAY R-III SCHOOL DISTRICT ANNUAL 2021-2022 HEALTH HISTORY FORM
7th-12th 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.
- **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.
- **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.
- **Antacid Chewable Tablets** (Calcium Carbonate 750mg) for heartburn, indigestion, and/or upset stomach. Given according to the label on medication packaging. Will administer only one time per school day.
- **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, vaseline, carmex
- **Misc. Topical Prevention:** sunscreen, insect repellent
- Nurse may obtain a **fingerstick** for glucose to evaluate known diabetes or any student with complaints symptoms of low blood sugar, including, but not limited to: dizziness, shaky, clamminess / sweating, light headed, hunger, confusion, tachycardia, weakness, tingling, coordination changes, or seizure like activity

If your child is given oral medication (except for cough drops, throat lozenges, or peppermints) at school, would you like to be notified? Circle one: Yes / No

If yes, would you like to be notified before or after administration of medication? Circle one: Before / After

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

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

Emergency contact: _____ **phone number:** _____