OTHS District 140 Confidential Health Information

Please answer the following for your child. Circle "yes" or "no" and answer the questions as appropriate.

Students Name: ______________________________ **Birthdate:** ______________ **Does your child have...?**

ADHD/ADD Yes No
*Medication needed at school? Yes No
If yes, please request medication form from Nurse, Room 205

Allergies Yes No
*To Foods, Beestings, Drugs? Please List ______________________________
Describe allergic reaction ______________________________
Has allergy required emergency care in the past? Yes No
*Does your child have an Epi-Pen? Yes No
If your child will need Epi-Pen at school, please request form from Nurse, Room 205

Asthma Yes No
If yes, when was last attack? ____________ Triggers? ______________________
Diagnosed by Doctor? Yes No
*Is medication needed at school? Yes No
If yes, please request medication form from Nurse, Room 205

Diabetes Yes No
Does your child use insulin or oral medication? Yes No
*Is medication needed at school? Yes No
*Is blood sugar monitoring needed at school? Yes No
*Is Glucagon needed at school? Yes No

Seizures Yes No
If yes, please describe type: ______________________________
Does your child take seizure medication? Yes No
Does your child take seizure medication? Yes No
*Is medication needed at school? Yes No
If yes, please request medication form from Nurse, Room 205
Is your child currently under a Doctor's care? Yes No
When was his/her last seizure ______________________?

Vision/Eye Concerns Yes No
Does your child wear glasses or contacts? Yes No
Please list any vision concerns: ______________________________

Hearing/Ear Concerns Yes No
Does your child have a known hearing loss? Yes No
Does your child wear a hearing aid? Yes No
If yes, right, left, or both

Heart Condition Yes No
If yes, please list condition ______________________________

Mental/Emotional Concerns Yes No
If yes, what services has he/she been provided ______________________

Other Health Concerns Yes No
If yes, please describe ______________________________
Will your child need special procedures performed at school? Yes No

Does your child take medications daily? Yes No
List medications: ______________________________

Give an explanation of any special instructions to teachers and school nurses.

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