Steamboat Springs School District
Student Health Information 2009-2010

This form will be given immediately to the Nurse upon registration and will be stored only in their files. Information obtained on the Health History is solely used by the district health staff to ensure that sound decisions are made to meet the health needs of your student. Health information will ONLY be shared with school staff on a "need-to-know" basis and parents/guardians will be included in this process. Health information will not be shared with any other outside health providers without the expressed written permission of the parent/guardian. If you have any questions or concerns, please contact your student's school nurse.

Student Name: ___________________________________ Date of Birth:_________________ Grade: ______

Medical Alerts / Significant Health Concerns (Asthma, Serious Allergies, Seizures, etc).

Medical Alert 1:____

Medical Alert 2:____

Medication Information

Is your child taking any medication regularly? Yes ☐ No ☐

If yes, please list the medication(s):____

Is your child allergic to any medication(s)? Yes ☐ No ☐

If yes, please list the medication(s):____

Indicate allergic reaction: ____

Student Medication Request Release Agreements are available at the school office. This form must be completed for any medication a student will need to take during school hours.

Immunization Information

*In order for your child to attend school, immunization documentation needs to be on file at the school by the first day of attendance. If immunization documentation is **NOT** complete, the student **MUST** see the school nurse or designee before enrollment can be completed.*

Doctor/Primary Care Provider

Name: ____ Telephone: Extension:______________

Emergency Information

In an emergency situation, the student will be transported to the nearest hospital. If a parent or legal guardian cannot be notified and immediate medical care is indicated, the school will call 911. However, the Steamboat Springs Schools will in no case accept financial responsibility for care.

Please complete 1, 2, and 3 only if you are new to the district:

1. Any problems during pregnancy or delivery? (Examples: Maternal health issues, C-section, Prematurity, etc.) **Yes** ☐ **No** ☐
   Explain: ____
2. Any problems during infancy? (Examples: Feeding difficulties, sleep disturbances, colic, developmental delays, illnesses, etc.)
   Yes ☐ **No** ☐ Explain: ____
3. What age did your child first walk alone? _________ What age did your child first talk? (2 words together) ________________

OVER

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Current Health Concerns

Does your child have **any** health concerns? Include any **new** concerns in the past 12 months **and** provide updates to **existing** conditions that may already be in our files:

Check and explain treatment where appropriate.		**Medication(s)**	Medication Given at Home? **Yes**	**No**	Medication Given at School? **Yes**	**No**
☐ Allergies						
☐ Asthma						
☐ Attention Deficit Disorder						
☐ Bowel/Bladder						
☐ Diabetes						
☐ Emotional/Behavioral						
☐ Fractures/Joint Muscle Problems						
☐ Physical Limitations/Restrictions						
☐ Head Injury or Loss of Consciousness						
☐ Hearing						
☐ Headaches						
☐ Heart						
☐ Hyperactivity						
☐ Seizures or Fainting						
☐ Skin Conditions						
☐ Speech						
☐ Surgeries/hospitalizations						
☐ Varicella (Chickenpox)	Date of disease:					
☐ Vision						
☐ Other						

☐ Student has **NO** health concerns

Please check all that apply:

☐ Glasses ☐ Contacts ☐ Hearing Aids ☐ Prosthesis or Physical Aids (please list)____________________________

☐ Other (explain) ____

Please initial to give permission to dispense Acetaminophen (Tylenol) at school:

_______ I give my permission for my child to receive two or three regular (325 mg) Tylenol (Acetaminophen) at the high school (depending on the severity of discomfort). Please note: 3 regular Tylenol are the equivalent of two Extra-Strength Tylenol. No other non-prescription (over-the-counter) medications can be dispensed by school personnel without a physician's written order!

Optional: Do your children have health insurance? Yes____ No____
If no, may a representative of the Visiting Nurses Association contact you regarding no-cost or low-cost health insurance? Yes___ No___

Parents/Guardians are responsible for providing full and updated details on any medical condition to the district health personnel. All information on this form is, to the best of my knowledge, current and complete.

Parent Signature:____ Date: _________________________