Deer Creek Public Schools

STUDENT HEALTH INFORMATION

Information on this form is to be filled out (updated) for each new school year. Please complete this form and upload to enrollment or email form to school nurse as soon as possible.

Name: _____ Birthdate: _____ Sex: M __ F __
Last First MI

School: _____ Grade: _____ Date: _____

SPECIAL HEALTH CARE PLANNING

If anything checked for Special Health Care Planning, upload corresponding form to your enrollment or email form to school nurse as soon as possible.

☐ **Diabetes – Date of diagnosis: _____ My student has:** ☐ insulin pump ☐ insulin pen ☐ injected insulin

☐ **Seizure Disorder –** My student needs emergency medication for **Seizures**. Name of medication: _____

☐ **Special Health Care Planning - My child has special health care needs such as - wheelchair, tube feedings, breathing tube, catheter, intravenous tubes or other. Please describe your child's conditions** _____

_____

☐ **My child has NONE of the health concerns/conditions listed above.**

LIFE THREATENING CONDITIONS

If anything checked for Life Threatening Conditions, upload corresponding form to your enrollment or email form to school nurse as soon as possible.

Asthma *Severe - (If this box is checked, please answer the following questions):

Yes ☐ No ☐ Does child use rescue inhaler routinely for asthma symptoms?
Yes ☐ No ☐ Has your child been hospitalized for asthma in the past year?
Yes ☐ No ☐ Has your child used steroids (prednisone) for asthma symptoms in the past year?

(If mild or moderate asthma, see box below 'Health History -Non-Life Threatening'

Allergy/Anaphylaxis - *Severe, with Epi Pen/ Auvi-Q prescription (for example: food, insect stings)

Allergen(s): _____

Other: _____

☐ **My child has NONE of the health concerns/conditions listed above.**

ALERT TO PARENTS/GUARDIANS: *The school **must** know of **LIFE THREATENING** conditions (for example severe allergy with anaphylaxis, diabetes, asthma) **prior to the start of school**, as these may require an Individualized Health Plan*
Contact your School Nurse or Health Services to begin the process for a student health care plan and/or medications at school.

HEALTH CONDITIONS

Check any of these conditions which your child has or has had:

☐ ADD/ADHD	☐ Blood Disorder	☐ Depression/Anxiety	☐ Heart Problems	☐ Other
☐ Allergies *mild or moderate (circle one)*	☐ Bowel/Bladder	☐ Dental	☐ Orthopedic/Bone	☐ Serious Injury
☐ Asthma *mild or moderate (circle one)*	☐ Cancer	☐ Hearing	☐ Social/Emotional/Behavioral	☐ Vision Concerns
				☐ Frequent headaches/migraines

If you have checked any of the above medical conditions/concerns, please explain: _____

_____

_____

Has the student ever visited an emergency room or hospital for the medical issue? YES / NO (circle) If yes, date: _____

_____

☐ **My child has NONE of the health concerns/conditions listed above.**