School District of Spring Valley
Home of the Cardinals

STUDENT HEALTH INFORMATION FORM

STUDENT'S FULL NAME:_____ DOB: _____

In order to meet your child's health needs while at school, we request the following information. Please complete and sign below even if no health needs exist. *This information will be utilized by the school nurse to develop a health plan for your child if necessary. Information regarding your child's health condition will be shared only with staff who need to know to assist your child in school.* Please make sure we have a way to contact you in an emergency.

Has your child been diagnosed with any of the following conditions by a healthcare provider (check all that apply)?

□ **No Known Health Conditions**

□ ADD/ADHD	□ Allergies (see below)	□ Emotional/Behavioral/Mental/Psych
□ Asthma	□ Headaches/Migraines	□ Dental Concerns
□ Diabetes	□ Heart Condition	□ Vision/Hearing
□ Epilepsy/Seizures	□ Orthopedic	□ Other: _____

If you checked any of the health conditions, please fill out the section below and the health office may contact you for more information. Prior to the school year starting, we may need certain documents such as Emergency Action Plans and Medication Forms depending on the type of health condition selected.

Details/Specifics regarding condition:

Allergies:		
□ Food	Specify:	**Does your child require emergency epinephrine: □ Yes □ No**
□ Insect	Specify:	**Does your child require oral antihistamine? □ Yes □ No**
□ Seasonal	Specify:	***If yes to either, a Provider's Order form/Action Plan is required and the medication will need to be provided by the parent/ guardian in order to administer it at school.***
□ Other	Specify:	

MEDICATION: Will your child need to take medication during the school day? □ Yes □ No

A non-prescription medication form must be completed and returned to the health office along with any non-prescription medication, in the original container. This form can be found on our district website.

A prescription medication form must be completed and returned to the health office along with any prescription medications. This form requires both a physician and parent signature. This form can be found on our district website. Medication must be dropped off by a parent and be in the original pharmacy labeled container.

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STUDENT HEALTH INFORMATION FORM (PG 2)

Primary Physician: _____
Clinic: _____
Clinic address: _____
Phone: _____

Family Dentist: _____
Clinic: _____
Clinic address: _____
Phone: _____

Emergency Contact:
Name: _____
Relationship: _____
Phone: _____

Secondary Emergency Contact:
Name: _____
Relationship: _____
Phone: _____

I hereby authorize the District Nurse, Health Assistant, Administrator, or other designated person to call any of the listed emergency contacts if needed for the care of my child. If my physician is not available (as listed), then an alternate physician may be contacted in an emergency. In case of a serious medical emergency or illness, 911 will be called. I authorize the release of any health information to the school district employees when necessary for the safety and educational benefit of my child.

Please contact the District School Nurse (715-778-5554 ext 3104) for any special health concern or change in health condition.

Parent/Guardian Signature: _____ Date:_____