Adrian R-III Health Office SY:25-26

Student Health History/OTC Permissions

Student Name(legal): _____ DOB: _____ Grade/Teacher:_____

Preferred name/nickname:_____ Sex assigned at birth:_____

Primary Contact:_____ 1st phone:_____ 2nd phone:_____

Secondary Contact:_____ 1st phone:_____ 2nd phone:_____

*Does your child have health insurance coverage ? □ Private □Medicaid □ None *Does your child have a DNR/DNAR? Yes/No

Assessment of student health/health history: To the best of your knowledge has the student been **diagnosed** with any of the following. **Please provide information in the comments section for any areas marked YES.** *Add additional pages if more space is needed.*

	yes	no	**Comments required for any YES answers.**
Allergies (non-life threatening)			Specify allergen & reaction:
Asthma/Breathing Issues/CF			Specify - Inhaler(circle):Yes//No At School:Yes/No***
Autoimmune Disorder/Disease			Specify -
Birth Defects/Chromosomal Abnormalities/Cleft Lip-Palate			Specify -
Blood Disorders (ex.Sickle Cell)			
Bowel /Bladder Issues/Incontinence			Specify -
Cancer (history of / current)			Specify -
Chronic Infection			Specify -
Communication Issue			Specify -
Diabetes (circle) Type I / Type II			Insulin Required: (circle) Yes / No ***
Gastrointestinal Disorder (ex IBS, Crohn's, Ulcers, CF etc)			Specify -
Heart Disease			Specify - Activity Restrictions(circle): Yes / No
Life Threatening/Anaphylactic Allergies / Reactions			Specify- Epinephrine prescribed: Yes/No***
Migraines			
Neurological Disorder (ex-Tourette's)			Specify -
Neuromuscular Disorder/Disability			Specify -
Orthopedic/Mobility issue(ex-fracture Scoliosis,Osgood-Schlatter, etc)			Specify-
Seizure Disorder			Specify type - ***
Other (not previously addressed)			Specify -

Please complete the rest of the form continued on the back of this page.

Adrian R-III Health Office (cont.)

*Does your child have any of the following **diagnosed** mental health conditions? [YES / NO] □ADHD □Anxiety □Autism □Bipolar □Depression □Eating Disorder □OCD □ODD □PTSD □ Other _____

*Does your child require any daily or as needed **Special Healthcare Procedures**?[YES / NO] (ex - blood sugar check, catheter care, nebulizer treatments, ostomy care, tube feeding, etc.) Please specify:_____

*Does your child have any dietary restrictions/needs: [YES / NO] (specify)_____***

*Does your child have a hearing impairment? [YES / NO] - If yes, do they have a (circle) hearing aid / FM system / cochlear implant.

*Does your child have a vision issue / diagnosis? [YES / NO] If yes, do they wear glasses or contacts? (circle) [YES / NO]

Prescribed medications: *(Add additional pages if more space is needed.)*

Medication	Dosage	Diagnosis	Where given: (Circle)	Time if given at school
			School / Home / Both	
			School / Home / Both	
			School / Home / Both	
			School / Home / Both	

Note that if medication is to be given at school, a signed Parent Medication Authorization will need to be completed and signed by a parent or guardian, and placed on file in the Health Office **prior to medication being given.

Over the Counter (OTC) as needed medication permissions: (given based on manufacturer label instructions for age / weight dosing,) ***If your student requires dye-free medications, they will need to be provided to the Health Office***

Medication	Yes	No	Dye free ✔
Acetaminophen (Tylenol)			
Ibuprofen (Advil/Motrin)			
Diphenhydramine (Benadryl)			
Tums			
Cough drops			
Oragel			
Triple Antibiotic Ointment (Neosporin)			
Hydrocortisone cream			

I attest that the information provided on this form is true and accurate to the best of my knowledge and belief.

Parent Name:(print)_____

Parent Signature:_____ **Date:**_____

***Indicates that an Action Plan &/or Individual HealthCare Plan &/or Doctor's note will need to be completed and placed on file in the Health Office.

–Legal name is requested for continuity purposes of immunization records and prescription labeling.