

SPRING VALLEY STUDENT HEALTH INFORMATION

STUDENT'S FULL NAME _____ DOB _____

Has your child had a serious illness and/or injury? (Please describe and include date)

Hospital: _____

Date: _____

Condition: _____

Does your child have:

Condition	Yes	No	Describe:
Attention Deficit Disorder			
Asthma			Treatment: _____
Seasonal Allergies			
Bee sting or insect allergy			
Food allergy			Food: _____ Treatment: _____
Behavior concerns			
Mental health concerns			
Birth defects			
Blood disorder			
Dental problems			
Diabetes			
Frequent headaches			
Hearing problems			
Heart condition			
Orthopedic problem			
Seizures			What kind of seizure?: _____ Treatment: _____
Toileting accidents and/or frequent urination			
Vision problem			
Other chronic condition			

**If your child currently has allergies, does he/she require an EPI-pen? YES NO

**If your child currently has asthma, does he/she require an inhaler or nebulizer? YES NO

Note: An Allergy Action plan, Asthma Action Plan, and Seizure Action Plan are **required** for all students with those health conditions. These forms will be sent to you by the School Nurse and **must** be filled out and signed by both your child's physician and a parent or guardian.

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

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

Medication:

A Nonprescription Medication Form must be completed and returned to the Health Office along with any nonprescription medication, in its 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 its original container.

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.

Signature (Parent/Guardian): _____ Date: _____

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