RETURN TO SCHOOL NURSE

OVERSTREET ELEMENTARY

Student Health Record

Grade_____ Homeroom_____

(Please complete: Information to be shared with teaching staff as needed)

Student's Name: _____ Date of Birth: _____ Age: _____

Address: _____ Home Phone: _____ Cell Phone: _____

Father/Mother/Guardian: _____ Work Phone: _____

Emergency Contact Person: _____ (relationship) _____ Phone: _____

Medicaid #: _____ Name of Health Ins.: _____

Student's Medical History

Problem	NO	YES	List symptoms and medicines needed...
Allergies ... to food			IF YES, SEE CAFETERIA EACH YEAR FOR FOOD RESTRICTIONS FORM Name:
... to medication			Name:
... insect bites or stings			Name:
... other (including seasonal)			Name:
Asthma			IF YES, ASTHMA ACTION PLAN NEEDS TO BE COMPLETED Medication:
Attention deficit (ADD, ADHD)			Medication:
Birth defect/physical handicap			List:
Bone or joint problems			
Convulsions (seizures/epilepsy)			IF YES, SEIZURE ACTION PLAN NEEDS TO BE COMPLETED Medication:
Diabetes (high blood sugar)			IF YES, DIABETES ACTION PLAN NEEDS TO BE COMPLETED Medication:
Earaches (frequent? tubes?)			
Emotional/Psychological disorder			
Headaches (frequent or takes medication)			
Heart Problems			
Hypertension (high blood pressure)			
Nose bleeds			
Sinus problems			
Speech and/or Hearing problems			
Stomach or digestive problems			
Surgery			
Vision (Seeing) problems			Glasses? ____ yes ____ no Contacts? ____ yes ____ no

Date of last physical/wellness checkup: _____ Date of last dental checkup: _____

Student's Healthcare Provider: _____ Phone #: _____

Student's Dental Provider: _____ Phone #: _____

Is the student taking daily medication? _____ NO _____ YES If yes, please name: _____

I give my permission for my child to participate in the school's health program which includes health education and basic screenings (vision, hearing, scoliosis, etc). I also give my permission for my child to receive first aid care and treatment per standing orders as needed. I give my consent for pertinent medical information to be shared between the medical provider and the school nurse and/or school personnel directly involved with my child at school.

Parent/Guardian Signature: _____ Date: _____