EAST UNION COMMUNITY SCHOOLS

Health Related Services

Annual Health Information -- TK-12

Student Name_____**Birth Date**_____**Sex**_____

Grade/Room_____**School attended last year**_____

HEALTH CONCERNS

Please put an (X) if your child has any of these health concerns:

____No health concerns

____ADHD/ADD

____Allergies (to what?)_____

____Asthma or other breathing problems

a. Has your child ever been diagnosed by a doctor as having asthma? ____Yes____No

b. Has your child had episode(s) of wheezing (whistling in the chest) in the last 12 months? ____Yes____No

c. In the last 12 months have you heard your child wheeze or cough after active playing? ____Yes____No

d. Other breathing problem (describe)_____

____Bladder problems/Bowel problems (describe)_____

____Chickenpox (list month and year he/she had disease)_____

____Diabetes: ____Type 1 ____Type2 (Managed by: ____Diet only ____Oral Med)
____Insulin Injections ____Insulin pump

____Heart Problems (describe)_____

____Seizures: Type (describe)_____

____Social/emotional/behavioral/mental health concerns (describe)_____

____Other health concern of significant history of problems (describe)_____

____Activity restrictions: (describe)_____

Any surgeries or hospitalizations? ____Yes____No If yes, explain _____

_____

EMERGENCIES: Does your child have a health problem that could result in an emergency? ____Yes____No

If yes, describe: _____

MEDICATIONS: List **ALL** medications that your child takes every day or when needed. A consent is **REQUIRED** for **ALL** medications taken at school. **A new consent is needed each school year**. Forms are available in the health office.

Medication Name	Purpose	Dose	How often taken?

EAST UNION COMMUNITY SCHOOL DISTRICT – *Student Health Form – 19/20*

VISION

____No vision problems
____Glasses/contacts prescribed
____Wears glasses/contacts all of the time
____Wears glasses in classroom only
____Glasses lost/broken
____Has (or has had) glasses but does not wear
____Other (describe)_____

HEARING

____No hearing problem
____Frequent ear infections (more than 3 per year)
____Has ear tube(s) Date inserted _____
____Hearing loss ____right ear ____left ear
____Hearing aid(s) ____right ear ____left ear
____Aids lost/broken
____Has (or has had) aids but does not wear
____Other (describe) _____

DENTAL

____By checking this, I give permission for the **I-Smile** program to provide a dental screening, @ NO CHARGE, if needed, by a registered dental hygienist. This oral screening does not take the place of your child's regular visit to the dentist, but it does satisfy the Iowa school mandate audit.

HEALTH INSURANCE

____My child has health insurance: If yes, what kind _____
____My child has no health insurance

HEALTH CARE PROVIDERS:

Does your child have a doctor or clinic where they usually go for health care? ____Yes ____No

If there is no family physician, will the choice made by the school, be satisfactory? ____Yes ____No

Hospital preference:_____

Name of Doctor or Clinic	Location and Phone	Approximate Date of Last Exam
Primary Health Provider (regular doctor)		
Eye Specialist		
Ear Specialist		
Dentist		
Other Specialist (specify type)		

Comments:

This health information may be shared with East Union school staff as needed. If you do not want this health information shared, please contact the school nurse.

Parent/Guardian Signature: _____Daytime Phone:_____

Print Parent/Guardian name:_____Today's Date: _____