St. Stanislaus Health Information for 2020-2021 School Year

Name: _____ Date of Birth: _____ Male / Female Grade: _____

Father/Guardian: _____
Home Phone #: _____
Work Phone #: _____
Cell Phone #: _____

Mother/Guardian: _____
Home Phone #: _____
Work Phone #: _____
Cell Phone #: _____

Emergency Contact: _____ Relationship: _____
Home #: _____ Work #: _____ Cell #: _____

Emergency Contact: _____ Relationship: _____
Home #: _____ Work #: _____ Cell #: _____

Doctor: _____
Exam in Past Year: Yes / No
Last Exam Date:

Dentist: _____
Exam in Past Year: Yes / No
Last Exam Date:

Eye Doctor: _____
Exam in Past Year: Yes / No
Last Exam Date:

What type of Health Insurance? Employer _____ Private _____ Medicaid _____ None _____

Please list any medications taken at **HOME:**

_____ Reason: _____

_____ Reason: _____

Please list any medications that will need to be taken at **SCHOOL:**

_____ Reason: _____

_____ Reason: _____

Please fill out the form titled "St. Stanislaus Medication Administration Form" so your child can be given these medications and as needed medications at school.

Special Education or Services student receives: _____
Childhood diseases, serious illness, and injuries: _____
Surgeries: _____
Condition that prevents PE participation: _____
Please provide a copy of your child's immunization record. It will be reviewed by the school nurse and filed in the student's permanent health record. The school nurse will provide written request for immunizations required to meet the state law.

Does your child have any of the following?					
ADD/ADHD: ☐ No ☐ Yes Daily medication taken: _____					
Allergies: ☐ No ☐ Yes To drugs, food, insects, etc? Please list: _____ Emergency treatment? _____ Has Epi Pen been recommended? _____					
Asthma: ☐ No ☐ Yes Triggered by: _____ Treatments: _____					
Diabetes: ☐ No ☐ Yes Takes insulin? ☐ No ☐ Yes Date diagnosed: _____ Comments: _____					
Eyes: Glasses: ____ Contacts: ____ Reading: ____ Distance: ____ Crossed: ____ Lazy Eye: ____ Difficulty Seeing: ____					
Ears: Please indicate which ear or if both are affected. Infections: ____ Tubes: ____ Hearing Difficulty: ____ Hearing Aid: ____					
Headaches: ☐ No ☐ Yes Please describe: _____					
Seizures: ☐ No ☐ Yes Daily medication taken: _____ Date of last seizure: _____ Describe seizure: _____					
Please CIRCLE other health concerns and DESCRIBE below:					
Anxiety	Blood Pressure	Depression	Lungs	Nose Bleed	Skin
Bladder	Bowels	Eating	Menstruation	Orthopedic (bones/joints)	Sleeping
Blood Disorder	Dental	Heart	Neurological (brain/nervous system)	Phobias (fears)	
_____ _____ _____					

If student requires medication at school, or a change in PE participation, please obtain the appropriate form in the school office. Health information will be shared with the people listed on this form and with school staff on a need to know basis. In the case of an emergency, the student may be transported to **_____ (hospital)** by medical emergency services.

Parent/Guardian Signature: _____ Date: _____