St. Stanislaus Health Information Form – 2024-2025 School Year

Name: ____________________ **Date of Birth:** ____________ **Male/Female** **Grade:** ________

Father/Guardian: ____________________ Preferred Phone #: ____________________	**Mother/Guardian:** ____________________ Preferred Phone #: ____________________

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 taken at **SCHOOL:**
______________________________ Reason: ______________________________
______________________________ Reason: ______________________________
Please fill out the form titled "St. Stanislaus Medication Administration Form" so your child may 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.

The following applies to items that may be used in the health room.

Please **CROSS OUT** any items that you **DO NOT** want to be used for/by your child:

Hydrocortisone cream	Lubricating eye drops (single use vials)	Petroleum jelly
Cough drops	Hand lotion	Saline solution
Aloe	Hand sanitizer	Triple antibiotic ointment
Calamine spray	Sunscreen	

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 needed? ☐ No ☐ Yes If yes, what is the treatment? ______________________
Asthma:	☐ No ☐ Yes	Triggered by: ______________________ Treatments: ______________________
Diabetes:	☐ No ☐ Yes	Taking insulin? ☐ No ☐ Yes Year or age diagnosed: ______________________ Comments: ______________________
Eyes:	Glasses: ____ Contacts: ____ → For Reading: ____ For Distance: ____ Crossed: ____ Lazy Eye: ____ Difficulty Seeing: ____	
Ears:	Please indicate which ear or if both are affected: Infections: _____ Tubes: _____ Hearing Difficulty: _____ Hearing Device: _____	
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 Bladder Blood Disorder	Blood Pressure Bowels Dental	Depression Eating Heart	Kidneys Liver Lungs	Menstruation Neurological (brain/nervous system) Nose Bleed	Orthopedic (bones/joints) Phobias (fears) Skin Sleeping

____

____

____

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: __________