Christ the King Catholic School
2019-2020 School Health Form

To Parent or Guardian:

The purpose of this form is to provide the school nurse with additional information regarding your child's health needs. The school nurse may contact you with the need for further information. This information will be kept confidential but is needed to meet the health needs of your child.

To help us keep your child's records current please update any information in your PlusPortal Account as needed.

Student Name _____Nickname_____

Birth date_____ Age ____ Weight_____ Sex Male Female Grade ____

Address _____

_____

Contact Information:
Primary Contact _____

Home Phone #_____Cell Phone #_____

Work Phone # _____Email _____

Secondary Contact _____

Home Phone # _____ Cell Phone #_____

Work Phone # _____ Email _____

In case of emergency and the above contacts are not available please notify:
1. Name_____ Relationship_____ Phone #_____
2. Name_____ Relationship_____ Phone #_____
3. Name_____ Relationship_____ Phone #_____
4. Name_____ Relationship_____ Phone #_____

Physician Name_____ Phone #_____

Preferred Hospital _____

Insurance information for child:

- ❑ **Private insurance**
- ❑ **Medicaid**
- ❑ **ALLKIDS**
- ❑ **No Insurance**

Part II Medical History
***Check only those that apply and return to school nurse**
***Please see Nurse for any Medications to be given at school**

- ❑ **No known health problems**

- ❑ **ADD (Attention Deficit Disorder)**
- ❑ **ADHD (Attention Deficit Hyperactivity Disorder)**
- ❑ **Aspergers Syndrome**
- ❑ **Autisim**
- ❑ **Medication_____**
- ❑ **To be given at school * See school nurse***

- ❑ **Asthma**
  - o **Uses inhaler at home**
  - o **Uses inhaler at school**

- ❑ **Allergies (SEVERE)**
- ❑ **Food_____**
- ❑ **Insects_____**
- ❑ **Environmental_____**
- ❑ **Medication_____**
- ❑ **Latex**
- ❑ **Hives / rash**
- ❑ **Breathing Difficulty**
- ❑ **Epi Pen**
- ❑ **Benadryl**
- ❑ **Other medications**

- ❑ **Bleeding problems (Hemophilia, Von Willebrands, frequent nose bleeds)**
- ❑ **Requires medication**

- ❑ **Cancer/Leukemia: specify_____**
- ❑ **Cerebral Palsy: _____**
- ❑ **Cystic Fibrosis: _____**
- ❑ **Dental problems: _____**

- ❑ **Diabetic**
  - o **Diabetes Type I**
  - o **Diabetes Type II**
  - o **Monitors blood glucose at school**
  - o **Insulin at school**
  - o **Glucagon at school**
  - o **Insulin pump**
  - o **Diet controlled**

- ❑ **Emotional/ Behavioral/ Psychological: (Specify)_____**
- ❑ **Genetic Disorder: (Specify)_____**
- ❑ **Headaches: (Specify)_____**
- ❑ **Hearing Problems**
  - o **Right ear**
  - o **Left ear**
  - o **Both ears**
  - o **Hearing loss**
  - o **Hearing aide**
  - o **Cochlear implant**

- **Heart Condition: (Specify)_____**
- **Hypertension (High blood pressure)**
- **Juvenile Arthritis/ Bone – joint problems: (specify)_____**
- **Kidney problems: (Specify)_____**
- **Scoliosis**
  - **Surgical Correction**
- **Epilepsy**
  - **☐Seizures ☐Type of Seizures**
  - **Medication: _____**

- **Sickle Cell Anemia**
- **Spina Bifida**
- **Special Diet**

- **Vision problems**
  - **Right eye**
  - **Left eye**
  - **Wears Glasses**
  - **Wears contacts**
  - **Other**

- **Therapy**
  - **Occupational Therapy**
  - **Speech Therapy**

- **Other medical conditions_____**
  _____
  _____

In the event of an illness or accident and the unavailability of the named physician, I consent to the treatment of _____ (student) by a physician, selected by school officials or those persons conducting or assisting in any school related function or activity, or hospital emergency room personnel.

_____ _____
Parent / Guardian Signature Date

Permission to place your child's name in a binder used by volunteer parents during lunch recess. Your child's name will be placed on the list of special medical needs children, only if your child has a special medical need. i. e. (severe allergy, diabetic, heart condition)

_____ _____
Parent / Guardian Signature Date