Niagara Falls City School District

Health Services

Student’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender at birth M\_\_\_\_ F\_\_\_\_\_

Mothers Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Mothers Place of Employment\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fathers Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Fathers Place of Employment\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Emergency: 1. Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 2. Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Describe your child’s current state of health (circle one): Excellent Good Fair Poor

|  |  |  |  |
| --- | --- | --- | --- |
| **A. Has your child ever:**  | **YES**  | **NO**  | **If Yes, please explain and include date:**  |
|  Had an ongoing medical condition  |   |   |   |
|  Seen a medical specialist  |   |   |   |
|  Had allergies:  |   |   | food environmental insect medication other  |
|  Been hospitalized |   |   |   |
|  Had an operation  |   |   |   |
|  Had an injury requiring an Emergency Room visit  |   |   |   |
|  Missed 5 days of school in a row due to illness/injury  |   |   |   |
|  Had a bone/muscle injury  |   |   |   |
|  Passed out, had a concussion or serious head injury  |   |   |   |
|  Had a convulsion/seizure  |   |   |   |
|  Had a vision problem or condition  |   |   |   glasses  contacts  |
|  Had a hearing problem or condition  |   |   |   hearing aid  cochlear implant  |
|  Worn dental bridge, braces or mouthpiece  |   |   |   |
|  **Have any family members under the age of 50 ever**:  | **YES**  | **NO**  | **If Yes, please specify:**  |
|  Had a heart attack  |   |   |   |
|  Had other serious health problems  |   |   |   |

 **CHECK ALL THAT APPLY TO YOUR CHILD:**

|  |  |  |
| --- | --- | --- |
| * ADHD
* Asthma/trouble breathing
* Autism/Asperger
* Dental Injuries
* Diabetes
* Ear Infections

  | GI Conditions (ulcer, reflux, IBS)* Headaches/migraines
* Heart Conditions
* High Blood Pressure
* Mental Health Condition

 (depression, eating disorder, anxiety, OCD, ODD, etc.)  | * Scoliosis
* Single Organ (kidney, testicle)
* Skin Condition
* Speech Condition
* Urinary Condition

Females Age Menstruation began \_\_\_\_\_\_ Date of last menstrual period \_\_\_\_\_\_\_ |

 Are there any condition that would prevent your child from participating in physical education or sports?  No  Yes

All medications have side effects and for your child’s safety, it is important for the School Nurse to have this information.

PLEASE LIST ALL MEDICATIONS YOUR CHILD TAKES AT HOME ONLY: *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

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**PLEASE BE SURE TO COMPLETE BOTH SIDES OF THIS FORM**

HAS YOUR SON/DAUGHTER:

Ever been a patient in a hospital? Yes \_\_\_ No \_\_\_ If yes, Date \_\_\_\_\_\_\_\_\_\_ explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Had any operations? Yes \_\_\_ No \_\_\_ If yes Date \_\_\_\_\_\_\_\_\_\_ explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Had any accidents? Yes \_\_\_ No \_\_\_ If yes Date \_\_\_\_\_\_\_\_\_\_ explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Is your son/daughter under a physician’s care now? Yes \_\_\_ No \_\_\_ explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is he/she allergic to any medication? Yes \_\_\_ No \_\_\_ explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has he/she participated in any psychological testing? Yes \_\_\_ No \_\_\_ If yes Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PLEASE ADD ANY ADDITIONAL PERTINENT FAMILY MEDICAL HISTORY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PLEASE LIST ANY ADDITIONAL CONCERNS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 (ATTACH AN ADDITIONAL SHEET IF NECESSARY)

 Parent/Guardian Signature **REQUIRED**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***B. PLEASE LIST & SIGN FOR ALL MEDICATIONS YOUR CHILD WILL NEED AT SCHOOL.***

 MEDICATION DOSE TIMES

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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I request that my child receive the medication as prescribed by our health care provider. THE NEW YORK STATE EDUCATION

DEPARTMENT REQUIRES THAT ALL MEDICATION IS TO BE FURNISHED BY ME IN A PROPERLY LABELED ORIGINAL CONTAINER

FROM THE PHARMACY AND MUST BE BROUGHT TO THE SCHOOL HEALTH OFFICE BY A PARENT OR GUARDIAN.

It is the policy of the School District of the City of Niagara Falls that these procedures must be followed or the school will not be responsible for the administration of the medication. I understand that the school nurse, will administer the medication.

 I agree if my child’s health care provided allows HIM/HER to self-carry the approved medication.

 Yes \_\_\_\_\_\_ No \_\_\_\_\_\_\_ Parent Initials \_\_\_\_\_\_\_\_\_

Signature (Parent or Guardian) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_