**Belle Plaine Schools**

**Annual Student Health Information**

In order to better meet your child’s health needs at school, please circle the appropriate number if your child has been medically diagnosed with any of the following conditions and write a brief explanation in the space provided below.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: \_\_\_\_ Birthdate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade: \_\_\_\_\_\_\_

Medical Clinic: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Provider Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Circle appropriate number(s) Circle appropriate number(s)

|  |  |
| --- | --- |
| 01 No Known Health Problems | 11 Ear / Hearing Problems |
| 02 ADD / ADHD (on meds: yes or no) | 12 Eye / Vision Problems |
| 03 Allergy-Animals (list below) | 13 Head Injury |
| 04 Allergy-Bee Sting (requires medication) | 14 Headaches (frequent / severe) |
| 05 Allergy-Food (list below) | 15 Heart Condition |
| 06 Allergy-Latex | 16 Nose Bleeds (frequent) |
| 07 Asthma - mild | 17 Orthopedic Condition/Scoliosis |
| 08 Asthma-needs medication during school day | 18 Seizures |
| 09 Blood Disorder | 19 Other (list below) |
| 10 Diabetes | 20 Recent Hospitalization or Surgery (list below) |

Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Circle appropriate answers

|  |  |  |
| --- | --- | --- |
| Yes | No | Medications Needed at School: |
| Yes | No | Physical Activity Limitations: |
| Yes | No | Special Dietary Limitations: |
| Yes | No | Medical Procedure Needed at School: |

***Note****:* ***Physician orders are required for all medications (except for secondary student over-the-counter pain medication), special diets, procedures, and activity restrictions***

***\*\*\*Be sure to inform the bus company of any of this information you feel necessary for them to know.***

***4.0 Bus Services: 873-2362***

**At the discretion of the school nurse, the above circled health information can be shared with appropriate school personnel**.

Parent/Guardian signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Physician Findings/Orders – Only needed if answered “yes” on middle section of form**

Significant Findings, Limitations, Medications or Dietary Needs \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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Healthcare Provider Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_