

Student Name: _____ D.O.B _____ Grade Level _____

Dear Parents/Guardians:

As you know good health is vital for an optimal learning experience. The district nursing staff asks that you please complete the section that applies to your child to help us meet your child's health related needs. If the school nurse feels the school needs more information about your child's health, you may be asked for more detailed information regarding your child's care at school. We invite you to call us if you have any concerns or issues regarding your child health. Thank You.

The DeKalb School District Nursing Staff

ASTHMA:

1. During the school year, how often does your child have attacks? _____ Date of last attack? _____
2. Causes of asthma attacks: allergies _____ infections _____ weather _____ exercise _____ emotions _____
other: _____
3. Usual symptoms: wheezing _____ coughing _____ difficulty-breathing _____ feeling of tightness in chest _____
bluish color in lips and fingernails _____ other _____
4. Treatment for attacks: rest _____ liquids _____ breathing exercises _____ medications (list) _____
5. Best Peak Flow _____
6. I GIVE PERMISSION FOR MY CHILD TO CARRY THEIR INHALER YES _____ NO _____

Physician order required for child to carry inhaler.

ALLERGIES:

1. What causes an allergic reaction in your child? _____
2. Usual or past reactions: redness _____ swelling _____ itching _____ hives _____ rash _____
swelling of face or tongue _____ difficulty swallowing, talking or breathing _____ weakness and/or dizziness _____
fainting or loss of consciousness _____ other _____
3. Action to be taken in case of reaction at school:
_____ Medication (s) (parents must supply) _____
_____ Call parent only _____ Call 911 and parent immediately (applies for all Epi-Pen use)

SEIZURE DISORDER:

1. Type of seizure _____
Age of diagnosis _____ Average length of seizure _____
Date of last seizure _____ Does your child take anti-seizure medications? Yes _____ No _____
Name of medication(s) _____
If "no" – off medication date _____
2. List special instructions for after a seizure _____

DIABETES:

Age of diagnosis _____ Type of insulin / medication used _____

PLEASE CALL SCHOOL NURSE TO DEVELOP INDIVIDUAL HEALTH CARE PLAN.

HEART CONDITION:

1. Describe problem / any restrictions _____
2. List medications, if any _____

OTHER HEALTH NEEDS OR CONCERNS: (include ADHD, any dental problems, dentures, orthopedic conditions, etc.)

MEDICATIONS NOT ALREADY LISTED:

GLASSES: Yes _____ No _____ for Near _____ for Distance _____ Other _____

Your signature below indicates your permission to share this health information with appropriate school personnel.

PARENT / GUARDIAN SIGNATURE _____ **Date** _____