

Information on this form is to be filled out (updated) for each new school year.

Bellevue School District-2012-2013
CONFIDENTIAL EMERGENCY HEALTH INFORMATION
From the Desk of the School Nurse

**Please complete BOTH sides of this form and return NO LATER than the
first day of school 2012**

Name: _____ Birthdate: _____ Sex: M/ F
Last First MI (circle)

School: _____ Grade: _____ Date: _____

ALERT TO PARENTS: If your child has a serious medical condition, *it is vital that you discuss this with your School Nurse and teacher(s) immediately.* The school must know of LIFE THREATENING conditions (for example severe allergy with anaphylaxis, diabetes, asthma) prior to the start of school.

In order to provide a safe and healthy environment for your child this information will be accessible to the following people: School Nurse, your child's teacher, office manager, personnel responsible for health room coverage and emergency medical personnel.

A. MEDICAL HISTORY: Check the ones that apply and describe under the comment section.

- | | | |
|---|---|---------------------------------------|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Headaches | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Anxiety/Panic attack | <input type="checkbox"/> Hearing Problem | (explain) |
| <input type="checkbox"/> Asthma * see below | <input type="checkbox"/> Heart Problem | |
| <input type="checkbox"/> AUTISM | | <input type="checkbox"/> PE activity |
| <input type="checkbox"/> Bee Sting allergy | <input type="checkbox"/> Kidney/urinary | Not Limited _____ |
| <input type="checkbox"/> Bowel problem | problems | Limited* _____ |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Muscle Disorder | *Explain: _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Neurological Concern | |
| <input type="checkbox"/> Color Blindness | <input type="checkbox"/> Orthopedic problem | |
| <input type="checkbox"/> Epi-Pen | <input type="checkbox"/> Seizures | |
| <input type="checkbox"/> Emotional Concerns | <input type="checkbox"/> Vision problems other than corrective lenses | |

Comments: _____

B. ASTHMA: *If you checked Asthma above please answer the following:

- Yes / No Has your child had severe exacerbation (intubation, ICU for asthma) in past 3 years?
- Yes / No Has your child been to the hospital (or hospitalized) in the past year due to asthma?
- Yes / No Has your child used steroids in the past 6 months for asthma symptoms?
- Yes / No SABA use two or more times a week – not related to exercise or respiratory illness

B. ALLERGIES: List allergies your child has that may cause a problem at school:

Cause of the allergy: _____ Treatment: _____
Cause of the allergy: _____ Treatment: _____

Please fill out other side - OVER

C. MEDICATION*: (Include prescription, over-the-counter and herbal medication.)

Name	Used to treat	Taken at school?
1) _____	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>
2) _____	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>
3) _____	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>

***IF MEDS ARE NEEDED DURING THE SCHOOL DAY (RX OR OVER THE COUNTER)**

PLEASE REQUEST MEDICATION ADMINISTRATION FORM FROM THE SCHOOL NURSE

***Before medication of any kind can be administered at school, a medication administration form, available in the office, must be completed by parent and physician and kept on file.**

D. List any other operations, injuries, hospitalizations, include dates: _____

E. VISION: Does student wear prescription lenses? _____ Glasses or Contacts lens ? (circle)

Name of Physician: _____ **Phone:** _____

Name of Dentist: _____ **Phone:** _____

PLEASE PROVIDE CORRECT – CURRENT CONTACT NUMBERS

(mother)

(father)

Parents/Guardian: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Email: _____

Home address: _____

City/Zip: _____

Student lives with: Mother: ___ Father: ___ Both parents ___

Other: _____