Health Care Assessment/Needs Form
Centralia R-6 School District

Please complete the following and return to the school nurse. Include any current information on medical conditions that may impact the education of the student or may require medical care during the school day or during school activities.

Name_____ Boy_____ Girl_____ Date of Birth _____
Last First MI
Grade_____ School_____ Teacher (if applicable)_____

Does student have: Private Insurance? Yes___ No___ Medicaid? Yes___ No___ ID#_____

Parent/Guardian_____ Phone#_____

Parent Employment _____ _____
Father Work Phone # _____ Mother Work Phone # _____
Emergency Contact _____ _____
(other than parent) Name Relationship Name Relationship

Name of last school attended _____ City _____ State _____
Has student previously attended another school in this district? Yes___ No___
If yes, name of school previously attended_____ Last Year Attended _____

Doctor's name_____ Date of Last Physical _____
Dentist's name_____ Date of Last Exam _____
Is your child under an orthodontist's care? Yes___ No___ Doctor's Name _____

Hospital Preference _____

Does your child have:

Allergies No Yes To drugs, food, insects, pollen? Please list:_____
Has the allergy required emergency action in the past? No yes
Comments:_____

Bee sting allergy No Yes Describe reaction:_____
Any difficulty breathing?_____ Emergency medication?_____

Epinephrine allergy No Yes
**In the event of severe allergic reactions that cause anaphylaxis, epinephrine will be administered in accordance with protocols provided by the authorized prescriber, except for students authorized to carry and self-administer epinephrine in accordance with Board policy.*

Asthma No Yes Triggered by:_____ Treatments:_____
Diagnosed by doctor?_____ Date_____

Diabetes No Yes Takes insulin? No yes Date diagnosed_____

Epilepsy/ No Yes Describe seizure_____
Seizures Date of last seizure_____ Medication_____

Heart Condition No Yes Describe_____
Any physical restrictions?_____ Medication_____

Bone or joint problems No Yes Describe_____
Any physical restrictions?_____

Complete the following regarding health concerns that pertain to your child:

Takes daily medication? At home? No Yes
At school? No Yes
Emergency only? No Yes
Name of medication_____ Dosage_____ Times taken_____

Reason_____

Eyes: ( ) glasses ( ) reading ( ) distance ( ) contacts ( ) crossed ( ) lazy eye ( ) difficulty seeing

Ears: ( ) frequent infections ( ) tubes ( ) hearing difficulty Explain_____
( ) hearing aid ( ) right ( ) left ( ) wear at school Other_____

Other Concerns:
( ) nosebleeds ( ) eating ( ) sleeping ( ) bowel ( ) requires diapering ( ) skin
( ) bladder ( ) requires catheterization ( ) bedwetting ( ) dental ( ) blood disorder
( ) neurologic ( ) lungs ( ) headaches ( ) menstruation ( ) blood pressure
( ) phobias/ fears ( ) ADD/ADHD

Immunizations:
Upon enrollment, provide a copy of your child's immunization record. It will be reviewed by the school nurse and filed with the student's permanent school health record. The school nurse will provide a written request for immunizations required to meet state law.

Childhood diseases, serious illness, and injuries:_____

Surgeries:_____

Condition that prevents PE participation:_____

Special Education or services student receives:
( ) LD ( ) speech/language ( ) OT/PT ( ) counselor ( ) BD ( ) EMH
( ) other_____ ( ) special diet_____

Requires special health care (explain):_____

Health information or concerns:_____

Special procedures required:_____

If student requires medication at school, or a change in PE participation, please obtain the appropriate form in the school office. Health information will be shared with the persons listed by the parent on this form and with the school staff on a need to know basis. In the case of an emergency, the student may be transported by medical emergency services.

_____ _____
Parent/Legal guardian signature Date