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.)**

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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_____________