Bluffton-Harrison MSD
Student Health Information 2009-2010

Parent/Guardian: **Please complete both sides**.

Student name: _____ Grade _____ Birth date _____
Physician _____ Phone _____

Medical History/Conditions
For each of the following, please circle "Yes" or "No". For "Yes" answers, please list any medications taken or any special care for the condition, or notes about the condition. If the student takes medication for the condition, please fill out medication section on the back page. For allergies, please give additional information about the allergy in the allergy section. If needed, please use the back of the page for additional information.

	Condition	**Yes/No**	**Medication/Special Care/Notes**
1.	Acid reflux/GERD/frequent vomiting	Yes/No	_____
2.	ADD/ADHD (Attention Deficit Hyperactivity Disorder)	Yes/No	_____
3.	Asthma (If yes, please see nurse for school instructions)	Yes/No	_____
4.	Autism Spectrum Disorder	Yes/No	_____
5.	Bee /Insect sting allergy*	Yes/No	_____
6.	Bone, joint, or muscle disorders/fractures	Yes/No	_____
7.	Bladder or Kidney concerns/control problems	Yes/No	_____
8.	Bowel concerns (constipation, loose stools)	Yes/No	_____
9.	Cerebral Palsy (C.P.)/Neurological disorders	Yes/No	_____
10.	Diabetes (If yes, please see nurse for school instructions)	Yes/No	_____
11.	Digestive concerns/special diet/tube fed	Yes/No	_____
12.	Ear or hearing concerns	Yes/No	_____
13.	Emotional/psychological	Yes/No	_____
14.	Epilepsy/Seizure disorder	Yes/No	_____
15.	Eye or vision concerns	Yes/No	_____
16.	Food allergy**/Intolerance (milk, dairy products, etc.)	Yes/No	_____
17.	Genetic disorder/Chromosome disorder/Syndrome	Yes/No	_____
18.	Heart/Congenital Heart Defect/Heart Surgery	Yes/No	_____
19.	Headaches (frequent, migraines, sinus)	Yes/No	_____
20.	Medical Equipment (feeding tube, wheelchair, etc)	Yes/No	_____
21.	Pollen, dust, environmental allergies	Yes/No	_____
22.	Shunt/hydrocephalus	Yes/No	_____

Allergies
For any allergy, please list the type of reaction, and medication/treatment needed*:

Allergy	**Type of Reaction**	**Medication/Treatment Needed**
_____	_____	_____
_____	_____	_____
_____	_____	_____

***If emergency medications are needed for allergies, fill out a "Medication Authorization Form" and bring the medication to school in the original container.**

****If the student has a food allergy or needs food substitution in the school cafeteria, a doctor note is required.**

Continue and complete the back side of this form.

Medications

Does this student take any medication (prescribed and/or over-the-counter/OTC)? Yes/ No

Medication Name	**Dose and Time(s) Taken**	**Reason for Medication**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Most medications may be taken at home. Will this student need to take medication **during school hours?***

Yes/No Explain: _____

***Note: BH MSD policy requires all medication given to students to be supplied by parent/guardian. All medication must be in the original container. Prescription medication given at school requires a medication permission form signed by the physician and parent/guardian. Over-the counter medication (pain medications, for example) must have a note from the parent. Herbal supplements require a prescription by a physician plus an herb authorization form. All forms are available from the nurse.**

Immunizations

Has the student received any immunizations in the past year? Yes/No List new: _____

In order to keep the student's immunization record up-to-date, be sure to give a copy of any new immunizations with dates to the nurse.

Vision Exams

Has the student been seen by an optometrist (eye doctor) in the past year? Yes/No (If yes, please have the optometrist fill out a vision exam report and turn it in to the nurse. See the school nurse if you need a form.)

Recent injuries/Fractures/Surgeries/Hospitalizations

Please list any recent injuries, fractures (broken bones), surgeries, or hospitalizations with dates:

_____

_____

Other information

Please give any additional information that would be helpful for the staff at school to know to keep the student safe and healthy:

_____

_____

_____

_____

To ensure the care of my child, I have read and agree that pertinent health information may be provided to appropriate school staff. This will be done only on a "need to know" basis, in a confidential manner. I agree that the school nurse may consult with my child's family doctor/health care provider(s) about the medical conditions on this form. I agree to alert the school nurse and my child's teacher, in writing, of any change in medication and/or health status of my child. I will furnish the school with a current telephone number and address in case of an emergency. The above permission will be valid through June 2010, unless I revoke the permission in writing.

Parent/Guardian Signature_____ Date _____

Please complete and return by the first day of school.