2009-2010

Bellevue School District

CONFIDENTIAL EMERGENCY HEALTH INFORMATION

From the Desk of the School Nurse

PLEASE COMPLETE FORM & RETURN AS SOON AS POSSIBLE

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

School:_____ Grade:_____ Teacher:_____

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. It is very important to know of **LIFE THREATENING** conditions (for example asthma, diabetes, nut/insect allergies).

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 to your child and describe under the comment section.

_____ ADD/ADHD
_____ Anxiety/Panic attack
_____ Asthma
_____ Bee Sting allergy
_____ Bowel problem
_____ Cerebral Palsy
_____ Diabetes
_____ Color Blindness
_____ Epi-Pen
_____ Emotional Concerns

_____ Headaches
_____ Hearing Problem
_____ Heart Condition
_____ Kidney/urinary problems
_____ Muscle Disorder
_____ Neurological Concern
_____ Orthopedic problem
_____ Seizures
_____ Vision problems

_____ Other:_____ (explain)

_____ PE activity
Limited _____
Not Limited _____
Explain:
_____
_____

Comments: _____

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

Cause of the allergy: _____ Treatment: _____

Cause of the allergy: _____ Treatment: _____

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

	Name	Used to treat	Taken at school?
1)	_____	_____	Yes ☐ No ☐
2)	_____	_____	Yes ☐ No ☐
3)	_____	_____	Yes ☐ No ☐

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 recent operations, injuries (especially head injury), hospitalizations, Give dates:

_____

E. Does your student wear contact lens? _____ Glasses?_____

F. Name of Physician:_____ _____ **Phone:**_____

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

Today's date: _____

G. Parents name: _____ _____
(mother) (father)

Home Phone: _____ _____

Work Phone: _____ _____

Cell Phone: _____ _____

Home address:_____
City/Zip:
Email:

Student lives with: Mother:_____ Father:_____ Both parents____
Other: _____

IN THE EVENT OF A MEDICAL EMERGENCY, IF A PARENT OR GUARDIAN CANNOT BE REACHED, PLEASE CONTACT:
Name: _____ Home phone:_____ Cell phone:_____