MEDICAL ALERT/HEALTH INVENTORY

Child's name_____ Birth date _____ School _____ Grade _____

Physician_____ Preferred Hospital_____ Health Insurance Co._____

Health history: Please complete both sides of this form. This information is considered CONFIDENTIAL and is for use by the nurse, health room staff, teacher(s), building administrators, and others as needed to ensure your child's safety and protection at school.

Indicate below the medical conditions that may affect the student's school program or school performance.

Computer code	HEALTH HISTORY/ CONDITION	Current		MEDICATION (S) "Medication at School" form must be completed for school administration	Check (√) if needed at school	COMMENTS
		Yes	No			
EG & OB (staff enter both codes and list allergy type)	Anaphylactic allergy (life threatening) Insect ____ Bee ____ Food ____ Environmental _____			(service animals may be in buildings)		**Specify source of allergy ie- peanuts, smoke, dogs etc.**
EE ED EC EB	Allergy- mild/localized Insect ____ Bee ____ Food ____ Environmental _____ Other (antibiotic etc)- mild to severe ___			(service animals may be in buildings)		**Specify source of allergy ie- peanuts, smoke, dogs etc.**
RB RC RD RE	Asthma- Mild ___ Moderate ___ Severe ___ Reactive Airway Dis. ___					**Specify factors contributing to flair-ups:**
EJ	Cystic Fibrosis					
GF GG GI	Encopresis ___ Food Intolerance ___ GI- other ___					**Specify condition if "GI-other":**
CA CD CE CG	Cardiac Disorder ___ Heart Murmur ___ Hypertension ___ Cardio-vascular other ___					**Specify condition if "Cardio-vascular -other":**
BB BD	Hemophilia ___ Blood cond. –other ___					**Specify condition if "Blood cond. –other":**

COMPLETE BACK SIDE AND SIGN/DATE- RETURN TO STUDENT'S SCHOOL OFFICE

Code	Health history/condition	Current		MEDICATION (S) "Medication at School" form must be completed for school administration	Check (√) if needed at school	COMMENTS
		Yes	No			
EA EK EU EO	Adrenal Disorder ___ Diabetes- Type 1 ___ Thyroid Disorder ___ Endocrine and/or Metabolic –other ___					**Specify condition if "Endo/Metabol. – other":**
NP NU	Seizure Disorder ___ Traum Brain Inj ___					
PA	Anxiety Disorder					
YB YD	Hearing impaired ___ Visually impaired ___					**Exam date/results:** **Exam date/results:**
MD MC ME	Muscular dystrophy ___ Juv. Rheum. Arth __ Muscul/skeltl- other ___					**Specify condition if "Musculo/skeltl – other":**
NE	Cerebral Palsy					
UA UE UD	Chron. Renal Failure __ Incontinence-Bladder/bowel control __ Genito/Urinary other ___					**Specify condition if "Genito/Urinary- other":**
TA TI	Neoplsm (cancer) -blood and/or circulatory ___ Neoplsm (cancer)-other ___					**Specify condition if "Neoplsm (cancer) –other":**
NS	Spina Bifida					
NB	ADD/ADHD					

Other Conditions or Comments: _____

No child may take medication (prescription or over-the-counter) at school without a completed medication administration form (s) including signature by Health Care Provider and/or parent/guardian. Forms may be picked up in the office or at your physicians. **Please provide information to school in writing if you have special instructions regarding religious beliefs.**

* **Do you need health insurance for your children?** Please check the box if you are interested in being contacted by our Education Advocate/ school staff: ☐
Do not check the box if you already have health insurance coverage.

AUTHORIZATION FOR EMERGENCY PROCEDURE: If the parent(s)/guardian named above cannot be reached at the time of an emergency, and if immediate observation or treatment is urgent in the judgment of the school authorities, I authorize and direct the school authorities to contact emergency medical aide and send the student to the hospital or doctor most easily accessible. I understand that I will assume full responsibility of the payment of any services rendered.

Parent/guardian signature_____ Date_____