Guthrie Public Schools

# STUDENT HEALTH INFORMATION

*Information on this form is to be filled out (updated) for each new school year. Please complete this form and return to your school as soon as possible.*

Student: _____ Birthdate: _____ Grade: _____ School: _____

Parent/Guardian: _____ Phone: _____ Date: _____

☐ **My child has NO health conditions/concerns**

## SPECIAL HEALTH CARE PLANNING

*If you checked a box for Special Health Care Planning, attach corresponding form to your enrollment or email form to district nurse.*

☐ **Diabetes** – Date of diagnosis: _____ **My child has:** ☐ insulin pump ☐ insulin pen

☐ **Seizure Disorder** – My child needs emergency medication for **Seizures**.
Name of medication: _____

☐ **Special Health Care Planning** - My child has special health care needs such as – tube feedings, breathing tube, catheter, or other. Please describe your child's condition(s): _____

_____

## LIFE-THREATENING CONDITIONS

*If you checked a box for Life-Threatening Conditions, attach corresponding form to your enrollment or email form to district nurse.*

☐ **Allergy/Anaphylaxis - Severe**, with Epi-Pen/Auvi-Q prescription (for example: food, insect stings)

Allergen(s): _____

☐ **Asthma - Severe** (please answer the following questions):

Yes ☐ No ☐ Does your child use a rescue inhaler routinely for asthma symptoms?

Yes ☐ No ☐ Has your child been hospitalized for asthma in the past year?

Yes ☐ No ☐ Has your child used oral steroids for asthma symptoms in the past year?

☐ **Bleeding Disorder**: _____

- *If asthma or allergy is mild or moderate, use box in 'Health Conditions' below*

***ALERT TO PARENTS/GUARDIANS:*** The school must know of life-threatening conditions (for example severe asthma, allergy with anaphylaxis, hemophilia) prior to the start of school, as these may require an emergency plan. Contact your School to begin the process for a health care plan and/or medications at school.

## HEALTH CONDITIONS

Check any of these conditions which your child has:

☐ ADD/ADHD ☐ Blood Disorder ☐ Depression/Anxiety ☐ Orthopedic/Bone

☐ Allergies mild or moderate ☐ Bowel/Bladder ☐ Heart Problems ☐ Vision Concerns

☐ Asthma mild or moderate ☐ Cancer ☐ Hearing Loss ☐ Other

If you have checked any of the above health conditions, **please explain**: _____

_____

_____