**Barstow Unified School District**

**Student Health Information**

Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Grade \_\_\_\_\_\_\_ Birthdate\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Last First Initial***

Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PARENT/GUARDIAN:** Please check the appropriate box(es), if any, that best describes your student’s current health condition(s) and return the completed form to school. Please provide specific information regarding conditions that may affect student learning and participation in school activities.

**MEDICATION:** All medication (prescription, over-the-counter, homeopathic remedies, vitamins, etc.), *which is to be administered during the school day, or during school-sponsored activities*, requires an Authorization for Medication Administration to be completed and signed by physician and parent. Students are not allowed to carry medication and/or inhalers without a signature by physician and parent on Authorization for Medication Administration form.

|  |  |  |  |
| --- | --- | --- | --- |
| **√** | **Health Condition** | **Medication** | **Specific Information** |
|  | ADD/ADHD |  |  |
|  | Allergy-Bee/Insect Life Threatening Yes  No |  |  |
|  | Allergy-Food Life Threatening Yes  No |  |  |
|  | Allergy-Medication Life Threatening Yes  No |  |  |
|  | Allergy-Other(animal,latex,etc.) Life Threatening Yes  No |  |  |
|  | Asthma-Mild  Moderate **Serious** |  |  |
|  | Autism |  |  |
|  | Birth Defect/Genetic Disorder |  |  |
|  | Bladder/Kidney Problem |  |  |
|  | Blood disorders (Chronic) |  |  |
|  | Cerebral Palsy |  |  |
|  | Colitis/Crohn’s Disease |  |  |
|  | Confidential Health Problem (call District Nurse) |  |  |
|  | Diabetes**(Requires meeting w/District Nurse)** |  |  |
|  | Down Syndrome/Intellectual Disability |  |  |
|  | Emotional/Psychological/Eating Disorder |  |  |
|  | Hearing Problems (infections, tubes, nerve damage, etc.) |  |  |
|  | Deaf/Hard of Hearing  Right Ear  Left Ear |  |  |
|  | Hearing Aids  Right Ear  Left Ear |  |  |
|  | Heart Problems–  No restrictions or  Restrictions |  |  |
|  | Hemophilia – Call District Nurse |  |  |
|  | Hypoglycemia/physician diagnosed |  |  |
|  | Medication Taken at Home, explain |  |  |
|  | Medication Taken at School **(Requires physician note)** |  |  |
|  | Menstrual Problems (Severe) |  |  |
|  | Migraine Headaches (physician diagnosed, list med) |  |  |
|  | Nosebleeds – Severe |  |  |
|  | Orthopedic Condition-Description: |  |  |
|  | Physical Activity Limitation **(Requires physician note)** |  |  |
|  | Prosthesis |  |  |
|  | Scoliosis (physician diagnosed) |  |  |
|  | Seizure Disorder-Type: |  |  |
|  | Sickle Cell Anemia (explain) |  |  |
|  | Skin Disorder |  |  |
|  | Speech Difficulties |  |  |
|  | Traumatic Brain Injury |  |  |
|  | Tuberculosis/or history of positive skin tests  Chest X-ray required w/positive skin test. List Med |  |  |
|  | Visual Impairment  Right Eye  Left Eye |  |  |
|  | Glasses/Contact lens  Distance  Reading |  |  |
|  | **Other Health Concern(s) not listed-Describe:** |  |  |
|  | **NO HEALTH CONCERNS AT THIS TIME** |  |  |

Do you currently have Health Insurance/Medi-cal?  Yes  No Dental Insurance  Yes  No Vision Insurance  Yes  No

If yes, please state name of insurance company or companies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**IF IN NEED OF EMERGENCY MEDICAL CARE AND WE ARE NOT ABLE TO CONTACT YOU, WE WILL CALL 911. STUDENTS MAY BE TRANSPORTED TO Barstow Community Hospital.**

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**Parent/Guardian Signature Date**

**PS 2015**