Our Lady of the Presentation School

STUDENT HEALTH INFORMATION & HISTORY

RETURN TO OLP HEALTH ROOM

Student Name: _____ Gender: _____ DOB: _____ Grade 2017 - 2018 _____

Allergies: List and describe reactions

Medication Allergies _____ Food Allergies _____

Seasonal Allergies _____ Insect Allergies _____

Latex Allergies _____ Other Allergies _____

Has your child ever been hospitalized for an allergic reaction? (Explain)_____

Is an Epi-Pen prescribed? _____ ***If so, please send one to the Health Room.***

Health Status: Please check any health problems your child has now or has had in the past.

- ☐ Asthma/Breathing Problems
- ☐ ADHD/ADD
- ☐ Bleeding/Clotting Disorder
- ☐ Cancer
- ☐ Depression/Anxiety
- ☐ Diabetes
- ☐ Digestion Problems
- ☐ Fainting Spells
- ☐ High Blood Pressure
- ☐ Immunosuppressant Condition
- ☐ Juvenile Arthritis
- ☐ Kidney/Urinary Problems
- ☐ Migraines/Headaches
- ☐ Nosebleeds (chronic)
- ☐ Orthopedic Problems
- ☐ Scoliosis
- ☐ Sinus Problems
- ☐ Seizures/Convulsions
- ☐ Skin Problems
- ☐ Ulcers
- ☐ Vision Problems
- ☐ Glasses
- ☐ Contact Lenses

Please list any conditions or concerns not listed above. _____

_____

Dietary Restrictions: _____

Operations, serious injury or other hospitalizations that affect your child now: (Type and year)

_____

Medications: Please list all medications your child is taking on a daily basis even if they will not be given at school. This is also important in the event of an emergency. _____

_____

_____

If your child receives medication at school, a completed **Medication Order and Consent Form** signed by the doctor, (or the prescription), needs to be on file in the Health Room. All medications must be in the original containers. All medications (including inhalers, cough drops, over- the- counter medicines, etc.) must be kept in the Health Room.
NO MEDICATION IS TO BE KEPT BY THE CHILD WHILE AT SCHOOL.

PLEASE NOTIFY THE HEALTH ROOM of any medication or health changes that occur throughout the school year.

FIELD TRIP PERMISSION: I give permission for my child(ren)'s teacher(s) to administer needed medication while on field trips. The school nurse will instruct the teacher on proper administration. ◯ YES ◯ NO

CONFIDENTIALITY: I give permission for the school nurse to share my child(ren)'s medical information with school personnel on a confidential, need-to-know basis. ◯ YES ◯ NO

Parent Signature_____ Date_____

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