



# 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.

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> Asthma/Breathing Problems  | <input type="checkbox"/> Diabetes                    | <input type="checkbox"/> Kidney/Urinary Problems | <input type="checkbox"/> Seizures/Convulsions |
| <input type="checkbox"/> ADHD/ADD                   | <input type="checkbox"/> Digestion Problems          | <input type="checkbox"/> Migraines/Headaches     | <input type="checkbox"/> Skin Problems        |
| <input type="checkbox"/> Bleeding/Clotting Disorder | <input type="checkbox"/> Fainting Spells             | <input type="checkbox"/> Nosebleeds (chronic)    | <input type="checkbox"/> Ulcers               |
| <input type="checkbox"/> Cancer                     | <input type="checkbox"/> High Blood Pressure         | <input type="checkbox"/> Orthopedic Problems     | <input type="checkbox"/> Vision Problems      |
| <input type="checkbox"/> Depression/Anxiety         | <input type="checkbox"/> Immunosuppressant Condition | <input type="checkbox"/> Scoliosis               | <input type="checkbox"/> Glasses              |
|   | <input type="checkbox"/> Juvenile Arthritis          | <input type="checkbox"/> Sinus Problems          | <input type="checkbox"/> 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 \_\_\_\_\_