Diocese of Des Moines EVERY PUPIL - EVERY FALL FORM **School Year:** _____

STUDENT NAME:_____ DATE:_____ BIRTH DATE:_____ GRADE:_____

Health Review

Breathing Problems	**Heart problems**	**Neurologic problems**	**Eating Problems**	**Gland Problems**
___ Asthma	___ Heart surgery	___ Frequent headaches	___ Stomach problems	___ Diabetes
___ Reactive airway	___ Heart murmur	___ ADHD/ADD	___ Heart surgery	___ Kidney Problems
___ Asthma	___ Other problems	___ Seizure disorder	___ Heart surgery	___ Thyroid problems

Doctor Ordered Special Need: ___ Contacts/Glasses ___ Hearing aids ___ Seat close to instruction ___ PE limitations

List Your Child's Allergies: Food_____ Medicine_____

Environmental_____ Insect_____ Other_____

List any illnesses, operations or accidents your child has had this past year:_____

List any emotional, social or other conditions that might affect your child's school performance: _____

List other health concerns you would like the nurse/teacher to know about:_____

Current Medications: _____ Medication to be given at school:_____

Emergency Information: Doctor Name:_____ Phone:_____

Hospital preference:_____

Parent information: Mother:_____ Home:_____ Work:_____

Family E-mail:_____ Cell:_____

Father:_____ Home:_____ Work:_____

Cell:_____

Is your child covered by insurance? Yes/No Carrier Name:_____

I give permission to the school nurse to share educationally relevant health and emergency information (to include medical diagnosis) with school staff on a need to know basis.

Parent Signature:_____ Date:_____