Resurrection-St. Paul School Health Form
(To be completed by parent)

Student's Name:_________________________________ Date of Birth:_______________ Grade:_________

Address:____ Zip Code: _____________

Sex (M/F):_______ School Year:________ Date form completed:___________________

Health History-Please indicate if student has any of the following:

___Asthma: List Triggers:________________________________ Treatment/Medication: _________________________________

___Bowel or Bladder Problems, please explain: ____

___Food Allergy:____________________________ Describe reaction: ____

Treatment/Medication: ____

___Medication Allergy:______________________ Describe reaction: ____

___Seasonal/Environmental Allergy:_____________________________Treatment/Medication: ____________________________

___Other Allergy:___________________________ Treatment/Medication: ____

___Insect/Bee sting (**circle**), please describe:________________________________Treatment/Medication: _____________________

___Attention Deficit Disorder:____Treatment/Medication: ____

___Bleeding Disorder:________________________ Treatment/Medication: ____

___Cardiac (Heart) Disorder, Diagnosis:____________________________ Signs and symptoms ____________________________

Does the student have any activity restrictions? ____

Treatment/Medication: ____

___Dental or Orthodontia devices: ____

___Diabetes: ___Insulin Pump ___Insulin Pen ___Syringe ___Glucagon ___Oral Medication

Insulin Type:___________________________ Insulin to Carbohydrate Ratio:______________

(Please obtain a separate Diabetes order form from the Health Room)

___Ear Infections: Frequency:_____________________ Date ear tubes inserted:___________ Are tubes still inserted? ___________

___Hearing Disorder: Does student have assistive devices (hearing aids, cochlear implant, etc.)? _______________________________

___Headaches (Please describe):_______________________________ Treatment/Medication: _______________________________

___Gastrointestinal Disorder:__________________________________ Treatment/Medication: _______________________________

___Immune System Disorder:__________________________________Treatment/Medication: _______________________________

___Muscular Disorder:_______________________________________Treatment/Medication: _______________________________

___Neurological Disorder:____________________________________Treatment/Medication:_______________________________

___Psychological or Mental Health Disorder, please describe: ____

Treatment/Therapy/Medication:____

___Seizures or Epilepsy: Type:_________________ Describe symptoms or aura:____

Medication:__________________________ Precautions needed at school:____

(Please complete reverse side)

Student Name:___________________________________

___Scoliosis: Surgery or Treatment dates:___________________________ Does student wear brace? ___________________________

___Surgeries/Hospitalizations and dates: ____

___Speech Disorder:__________________________ Has student or does student receive therapy? ______________________________

___Vision Disorder:________________________ Glasses:_____ Contact Lenses:______ Special concerns ________________________

___Other health problems or concerns: ____

Please use the space provided to discuss additional health concerns, medication , treatment or therapy:__________________________

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***If student requires medication to be administered at school, a separate medication order form is available in the Health Room and on the school's web site. No medication, prescription or over the counter, will be administered without this form, signed by the parent and a physician. If student requires an Epi-pen, a separate Epi-pen order form is available in the Health Room**.

Does your child have a health problem that would prevent full participation in school or physical education classes? _______________

If so, provide the reason or diagnosis ____

You will need documentation from your child's physician if restrictions are required.

Does your child require preferential seating at school?______ If so, why?____

Do you anticipate any major problems with adjustment?____ If so, explain ____

Does your child have a doctor?______Does your child have a dentist?_____

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Signature of Parent/Guardian