Kit Carson R1 SCHOOLS STUDENT HEALTH INFORMATION – Required Yearly / Must Sign Below and Date

School Year: _____

STUDENT:_____ **Grade:**_____ **Birth Date:**_____ **School:**_____

Does the student have HEALTH CONCERNS involving:	YES	NO	MEDICATION (Name, dosage)	NECESSARY MONITORING IN SCHOOL	COMMENTS OR DESCRIBE
ASTHMA / RESPIRATORY				Equipment:	
SEVERE ALLERGIES				FOOD LATEX INSECTS NUTS/PEANUTS	Is it life threatening? Type of reaction: Date of last reaction:
DIABETES				Equipment:	
HEAD INJURY					
SEIZURES/ NEUROLOGICAL MIGRAINES					Type & date of last episode:
HEART/BLOOD					
MUSCLES /BONES JOINTS / SKIN					
BLADDER/KIDNEY					
STOMACH /INTESTINES BOWEL PROBLEMS					
IMMUNE PROBLEMS					
HEARING CONCERNS				Hearing aides? Preferential seating?	
VISION CONCERNS				Glasses or contacts? Reading only?	Colorblind? Last eye exam?
GROWTH & NUTRITIONAL CONCERNS					Height: Weight:
DEVELOPMENTAL CONCERNS					
EMOTIONAL / BEHAVIORAL					
OTHER HEALTH CONCERNS					

Any YES answers on this page will result in the need to fill out the second page.

Any Changes Since Last Year? No_____ Yes____

Please list any routine or daily medications, treatments or therapies not listed above: **(Use back side if necessary)**

Activity restrictions in the school?

Special medical equipment required in school? (E.g. oxygen, wheelchair)

Have there been any significant changes in your child's health over the last year? Explain:
ILLNESSES, HOSPITALIZATIONS, ACCIDENTS/INJURIES and dates: **(use other side if necessary)**

Immunizations this last year? _____Date :_____

Health Care Provider(s) Name: _____Phone Number: _____

To *the Parent/Guardian*: This information will be shared only with those individuals in the school setting who have a legitimate need to know based on your child's educational and safety needs.

PARENT/GUARDIAN SIGNATURE_____ **DATE:**_____

HOME PHONE: _____ **CELL PHONE:**_____ **WORK PHONE:**_____

Please contact Kelli Adamson, the school nurse directly @ PHONE: 719-767-5616, if you would like to discuss any of the above information.

Page 2 HEALTH CONDITIONS OR SPECIAL CONCERNS BASIC HEALTH CARE PLAN

This information will be shared with school staff members who are working with your child and who may need to know. Please contact the school nurse if you have any additional concerns or information. The school nurse will contact you if additional clarification is needed or another care plan is required. This health plan will remain in effect for the school year, or until the student' health status or physician's orders change. Please notify the school nurse at 719-767-5616, whenever there is any change in the student's health status or plan of care.

Student's Name: _____ Date of Plan: _____
What is the health condition or concern: _____
_____
Parent / Guardian Name: _____ Home Phone: _____
Mother's Work Phone: _____ Father's Work Phone: _____
Primary Care Physician: _____ Phone: _____

What are the special considerations for school (describe: asthma triggers, activity restrictions, special diet, seizure precautions, other instructions, etc. that apply to school): _____
_____
_____
_____

Please list any/all known allergies: _____
_____

Medications: (Include those taken at home and school)

NAME OF MEDICATION(S)	DOSAGE	TIME TAKEN AT HOME	TIME TAKEN AT SCHOOL

Illnesses, hospitalizations, accidents, injuries: _____
_____
_____

Special Instructions:
Diet Restrictions: _____
Health Equipment: _____
Call Parent if: _____
Call 911 if any of the following occur: _____
Field Trips: _____
Any special instructions to handle an emergency? _____

Please circle if there has been an *additional SPECIALIZED health care plan* for the following in the past:
ADD / ADHD Asthma Diabetes Severe Allergy Seizures Other

As parent/guardian of this student, I give permission for this plan to be available for use in my child's school, and for the school nurse to contact the above-named physician(s) by phone, fax, or in writing when necessary to complete this plan.

PARENT /GUARDIAN SIGNATURE: _____ DATE: _____

SCHOOL NURSE SIGNATURE: _____ DATE: _____

Note: Detailed care plans will be developed by the school nurse as needed.

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