New Horizon School Health Services

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School year _____

Student Health Information

Student Name _____ Date of birth _____/_____/_____
1st Parent _____ Phone _____ Email _____
2nd Parent _____ Phone _____ Email _____
Address _____ City _____ Zip _____
Primary Doctor_____ Phone_____ Date of last exam _____/_____/_____
Dentist_____ Phone_ _____ Date of last exam _____/_____/_____

Medical History & Health Concerns

(Check all that apply, explain in the box below if needed)

☐None ☐ASD(Autism) ☐ADD/ADHD ☐Genetic/Congenital ☐Asthma/Breathing
☐Seizures ☐Diabetes ☐Heart Condition ☐Blood disease ☐Cancer
☐Sleep Disorder ☐Emotional Concerns ☐Eating Disorder ☐Migraines ☐Head Injury/Concussion
☐Serious Accident or injury ☐Bowel/Bladder ☐Stomach Aches ☐Surgeries ☐Skin Problems
☐Glasses ☐Hearing aids Other _____

Comments/Concerns including any recent/new hospitalizations or treatments, please explain and include dates:

ALLERGIES Does your child have any significant allergies? (Include known food allergies) ☐Yes ☐No If yes, list allergy(s) and symptom(s) of allergic reaction: How is the allergy treated?

Does your child have EPI PEN, EPI JR, Auvi-Q or equivalent prescribed to treat the allergy? ☐Yes ☐No

Medications

Does your child take daily medications at home? ☐Yes ☐No (If yes, please list the current medications)

Does your child require medication to be given at school? ☐Yes ☐No IF yes please indicate below

Name of Medication	Dose	Times Given	School Dose	Reason Given

PLEASE REMEMBER THAT THE SCHOOL NURSE CANNOT ADMINISTER MEDICAL MARIJUANA OR CBD OIL PER STATE LAW.
All medication to be given at school, requires a medical order from your child's physician. See your student handbook for rules/regulations regarding medication at school. Contact your school nurse with any questions.

DISEASE/DISORDER HISTORY

MEDICAL PROCEDURES OR TREATMENTS REQUEST Does your child have any special medical procedures or emergency treatments needed during school hours? ☐Yes* ☐No * If yes please describe below.

_____

Is your child under a doctor's care for **Seizures:** ☐Yes ☐No Rescue medication prescribed? ☐Yes ☐No
If Yes, **THIS MEDICATION MUST BE SENT TO SCHOOL IN PHARMACY LABELED BOTTLE/BOX WITH AN ORDER FROM THE PHYSICIAN. ****A **Seizure Action Care Form** will need to be completed by the Doctor to ensure a safe school environment for your child.
Is your child under a doctor's care for ***Diabetes:*** Check type: Type 1 ☐ Type 2 ☐
*A **Diabetic Medical Management Plan** will need to be completed by the Doctor to ensure a safe environment for your child. Any **Medication/Treatment** will require a doctor's order.
Is your child under care for **ASTHMA**? ☐Yes ☐No If yes, medication taken: _____
An **Asthma Action Plan form will need to be completed by the Doctor to ensure a safe school environment for your child.

I give permission for the following medication to be administered to my child during school.
☐Acetaminophen (Tylenol) ☐Ibuprofen (Advil) ☐Benadryl ☐Topical Benadryl
☐Topical "Insect Bite/Sting" Medication ☐Eye Wash Solution ☐Calcium Carbonate Antacid (Tums)
☐Potassium Iodide- (In case of radiation exposure emergency)

***All medical procedures or treatments to be given at school, requires a medical order from your child's physician** on hand with the nurse before any nursing procedures/treatments can be performed. Orders must be renewed for every new school year. Please contact your school nurse with any questions.

Does your child have any additional difficulties or considerations we should be aware of?
Vision concerns ☐No ☐Yes _____ Hearing concerns ☐No ☐Yes _____
Frequent ear infections ☐No ☐Yes _____ Frequent colds ☐No ☐Yes _____
Pneumonia ☐No ☐Yes _____ Weight gain or loss ☐No ☐Yes _____
Sleeping ☐No ☐Yes_____ Urination ☐No ☐Yes_____
Diarrhea or constipation ☐No ☐Yes _____Feeding problems ☐No ☐Yes _____
Dental problems ☐No ☐Yes _____
ACTIVITY RESTRICTIONS Does your child have any restrictions for physical activities? ☐Yes ☐No If yes, please outline the restriction below and include any special equipment used. Please be aware that the school nurse may ask for documentation of the restriction from your child's healthcare provider.

_____

IN CASE OF EMERGENCY Please contact the follow person. They have permission to pick up my child if I am not available
Name: _____ Phone: _____ Relationship_____
Name: _____ Phone: _____ Relationship_____
EMERGENCY CARE This information will be held in confidence and disclosed to school personnel to the extent necessary to protect the health and safety of the student. In case of an emergency, if the school is not able to contact me, I give permission to take my child to the nearest hospital or appropriate facility for medical attention. This medical information may be shared with, EMT's, and hospital personnel as needed. I understand a copy of this information will be sent with my child to the hospital. This information is current and correct; I understand that it is my responsibility as the parent/guardian to notify the school of new or existing health concerns or any changes in contact information. I understand that this health history form must be updated every school year.

Name of insurance _____ Group # _____ Policy #_____

SIGN _____ _____ _____
Parent/Guardian Signature Print Name Date

☐I would like the school nurse to call me regarding my child to provide additional information by phone.

My Health Passport

*If you are a **Health Care Professional** who will be helping me,*

PLEASE READ THIS

***BEFORE** you try to help me with care or treatment.*

My full name is: _____

I like to be called: _____

Date of Birth: _____/_____/_____

My primary care physician: _____

Physician's phone number: _____

This passport has important information so you can better support me when I am at school with my medical and behavioral needs.
Please keep this with my other notes where it may be easily referenced.

Contact person: _____ **Date completed:** ____/____/_____

Phone Number: _____ **Relationship:** _____

Contact Person: _____ **Relationship:** _____

Phone Number: _____ **Relationship:** _____

Medication I currently take: In the morning:

_____

During School: _____

Evening: _____

My Current Medical Conditions:

_____

_____

Do I have **seizures**? ☐Yes ☐No Medication? _____

Behaviors?

_____

My Current Allergies

To Food: _____

To Medication: _____

Environmental: _____

Do I have an EPI pen prescribed? ☐ Yes ☐ No

My brief medical history (past and current):

I communicate using (devices, sounds, verbal or non-verbal):

_____

If I am in pain, I show it by (low/high pain tolerance):

_____

If I get upset or distressed, the best way you can help is by:

_____

When drinking or eating you may assist me by:

_____

My Favorite foods and drinks are: _____

I do not like to eat or drink: _____

I am very sensitive to: (specific sights, sounds, odors, textures, etc.)

_____

Do bright lights or any lights bother me? _____

Things I enjoy doing that make me happy:

Is there anything else that is important to know about me?