CONFIDENTIAL: Colfax-Mingo School District, Student Health Registration Form

Legal Name: First, Middle, Last	Preferred Name To Be Called	Birthdate	Gender	Grade

PLEASE CONTACT THE SCHOOL NURSE IF YOUR STUDENT HAS ANY HEALTH CONCERNS THAT NEED ADDRESSED IN THE SCHOOL SETTING

MEDICAL HISTORY

Is the student ***currently*** being treated for any of the following medical condition(s)? *Check all that apply and explain below.*

ADD/ADHD:	Behavior:	Bone, joint, muscle:	Headaches:	Heart Condition:
Kidney/Bladder:	Nosebleeds:	Seizures	Skin	Stomach/Bowel:

OTHER MEDICAL/PHYSICAL CONCERNS: *(Please list and explain)*

_____

_____

_____

ASTHMA

Does your student have asthma? **Yes_____ No_____ *If Yes, Asthma Action Plan Required***

Is an inhaler used? **Yes_____ No_____** Asthma Medications:_____

DIABETES

Does your student have diabetes? **Yes_____ No_____ *If Yes, Diabetes Medical Management Plan Required***

ALLERGIES

Does your student have any allergies? **Yes_____ No_____** Does the student use an Epi-Pen? **Yes_____ No_____**

Food: _____ Medication:_____ Other:_____

Epi-Pen must be supplied by the parent* *Emergency food allergy or anaphylaxis action plan required

Does your student need a **special diet**? **Yes_____ No_____**

If yes, a diet modification request form must be filled out by a physician

HEARING/VISION

Do you have concerns about your child's hearing? **Yes____ No____** Does your child wear hearing aids? **Yes____ No____**

Do you have concerns about your child's vision? **Yes____ No____** Does your child wear glasses or contacts? **Yes____ No____**

MEDICATION *Please list all of your student's medications*

Name of Medication (Given at home or school)	Time medication is given and dose	Reason for medication

EMERGENCY PREFERENCES *Please make sure that this information is the same as provided to the office and in JMC.*

Contact #1: Name_____ Phone Number _____ Relationship _____

Contact #2: Name_____ Phone Number _____ Relationship _____

Contact #3: Name_____ Phone Number _____ Relationship _____

Hospital Preference: _____

OVER THE COUNTER MEDICATION

*Qualified school personnel may give over the counter non-prescription medications to my student according to package directions when my student has a minor health concern. Acetaminophen and Ibuprofen will only be given up to ***five times per school year***. Any further need for Acetaminophen or Ibuprofen will require a physician's note.*

Acetaminophen: **Yes_____ No_____** Ibuprofen: **Yes_____ No_____**

Antibiotic Ointment: **Yes_____ No_____** Calamine (Lotion or Spray): **Yes_____ No_____**

_____ _____ _____

Print Parent/Guardian Name Parent/Guardian Signature Date

Review Date	Review Signature	Any Updates or Changes