

Name of Student \_\_\_\_\_ Date of Birth \_\_\_\_\_ Grade \_\_\_\_\_

School previously attended: \_\_\_\_\_

Father \_\_\_\_\_ Mother \_\_\_\_\_ Home Phone \_\_\_\_\_

Address \_\_\_\_\_

Student’s Physician \_\_\_\_\_

Address of Student’s Physician \_\_\_\_\_ Telephone \_\_\_\_\_

**I. Family History** Health of father \_\_\_\_\_ Health of mother \_\_\_\_\_

Give cause of any deaths in immediate family \_\_\_\_\_

Indicate specifically any serious illness in immediate family (tuberculosis, heart disease, kidney disease, diabetes, cancer, epilepsy, mental illness): \_\_\_\_\_

**II. Immunization Record-This must signed by MD, or you may attach the immunization record from the doctor.**

**THE FOLLOWING ARE REQUIRED:**

- Diphtheria, Pertussis** (whooping cough) and **Tetanus**, at least 4 doses, the last dose not less than 6 months after the previous dose. Booster dose of Diphtheria and Tetanus recommended every 5 – 10 years.

Dates: 1<sup>st</sup> \_\_\_\_\_ 2<sup>nd</sup> \_\_\_\_\_ 3<sup>rd</sup> \_\_\_\_\_ 4<sup>th</sup> \_\_\_\_\_ Additional \_\_\_\_\_ Tdap \_\_\_\_\_ (required for all born after 1/1/97)

- Poliomyelitis** vaccine, live, trivalent, at least 3 doses, the last dose not less than 6 months after the previous dose. 4 – 5 doses are recommended.

Dates: 1<sup>st</sup> \_\_\_\_\_ 2<sup>nd</sup> \_\_\_\_\_ 3<sup>rd</sup> \_\_\_\_\_ 4<sup>th</sup> \_\_\_\_\_ Additional \_\_\_\_\_

- MMR** 1. \_\_\_\_\_ 2. \_\_\_\_\_

**OR**

**Rubeola**, (Regular Measles) two doses of live vaccine. This must be after 1<sup>st</sup> birthday, the SECOND before high school, NO EXCEPTIONS Date 1. \_\_\_\_\_ 2. \_\_\_\_\_

**Rubella**

(german measles) one dose of live vaccine Date \_\_\_\_\_

**Mumps**

one does of live vaccine Date \_\_\_\_\_

- Hepatitis B** Vaccine 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

(Now **required** to be completed before entry to school)

- Meningococcal vaccine** Date: \_\_\_\_\_ Verified by \_\_\_\_\_ M.D.

**III. Personal History - include dates. Please call the school nurse to discuss any conditions which will impact school attendance or performance. This section must be completed.**

<b>Allergies-type and severity:</b>	Cancer/Leukemia	Headaches/Migraines	Mumps
Medication	Chicken Pox	Head Injury/Concussion	Neurological Disorder
Bee Sting	Congenital Defects	Heart Problems	Pneumonia
Food	Dental Problems	Hepatitis	Recurrent Skin Eruptions
Other	Diabetes	Hernia	Rheumatic Fever
ADD/ADHD	Ear/Hearing problems	Kidney Problems	Scarlet Fever
Appendicitis	Epilepsy/Seizure Disorder	Lyme Disease	Speech Problems
Asthma	Foot Problems	Measles	Strept Infection
Bleeding/Clotting Disorder	Gastro-Intestinal	Meningitis	Tonsillitis
Bronchitis	German Measles	Mononucleosis	Vision Problems

Operations: (indicate dates) \_\_\_\_\_

Injuries: (indicate dates) \_\_\_\_\_

**IV. General Considerations**

Eyes: Glasses worn \_\_\_\_\_ Reading only \_\_\_\_\_ constantly \_\_\_\_\_ Contacts \_\_\_\_\_ Date of most recent examination \_\_\_\_\_

Average number of colds per year \_\_\_\_\_ Average duration \_\_\_\_\_

What recurrent or chronic conditions is the student predisposed to? \_\_\_\_\_

Has physical exercise ever been restricted? Explain \_\_\_\_\_

How much time has been lost from schoolwork during the past year because of illness? \_\_\_\_\_

If student's physical condition is normal, is permission given to participate in the regular sports, including football? \_\_\_\_\_

Has your son received psychological/psychiatric treatment? \_\_\_\_\_

Has your son had an evaluation for learning disability? \_\_\_\_\_

Is your son taking medication for above? \_\_\_\_\_

Name and address of psychiatrist/therapist and/or institution \_\_\_\_\_

Are there any pronounced family characteristics about which it might be profitable for either the nurse or the administration of the school to know? \_\_\_\_\_

**Please follow up with school nurse or guidance counselor in the fall regarding any special needs.**

**V. Medication**

Is your son currently taking any medication prescribed or over the counter, on a regular basis? Yes \_\_\_\_\_ No \_\_\_\_\_ If so please explain \_\_\_\_\_

**Please note that if your son does go on medication, or if there is a change in current medication, the School must be informed. If your child needs medication in school, please send the medication in the original prescription bottle and include written recommendation of the physician and written permission of the parent. If your child needs to carry an inhaler, epipen or any other medication for emergency use, the same policy applies. If your child needs an inhaler or epipen, an extra one should be kept at the nurse's office.**

**VI. The Authorization for Administration of Medications by School Nurses form must be completed by parent and doctor for prescriptions and over the counter medication.**

**VII. Parental consent:** I understand that for the educational needs and safety of my child, the school nurse may share information about my child with appropriate school staff. This will be done in a confidential manner.

- Yes, Permission is granted
- No, permission is not granted

**VIII. Parental Permission for treatment**

The law requires that parental permission be obtained for procedures on minors. The following consent form should be signed by the parents so that such procedures may be promptly carried out, and so that no unnecessary delays will occur with operative procedures. However, no operation will be performed, except in an extreme emergency, without parents being contacted and fully informed.

"If I cannot be reached, I give permission for such diagnostic, therapeutic, and operative procedures as may be deemed necessary for my son."

Parent/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_