Olton ISD
Student Health Form

Student Name:________________________________ DOB:______________ Grade:_________

Allergies:____________________________________ Reaction:___________________________

Past Medical History:____

Current Medication(s):____

Does your child require medication at school? **YES** **NO**

If yes, please list and complete a ***Medication Administration Consent Form***.

____

Does your child have any restrictions due to his/her health?

If yes, please list:____

☐ I **do** give consent for the school nurse to communicate my child's health information with applicable staff (teachers involved, counselor, principal).

☐ I **do not** give consent for the school nurse to communicate my child's health information to any other staff.

Emergency Contacts:

#1 Name:_______________________ Phone:________________ Relation:________________

#2 Name:_______________________ Phone:________________ Relation:________________

Please complete all necessary attached forms. If you have questions, please ask the nurse.

Nurse Use Only: do not complete this section

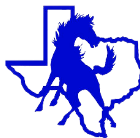
Immunizations: Current Provisional Catch-Up

Immunizations Needed:____

Forms Needed:

Form	Needed	Completed
Medication Administration		
PRN Medication Consent		
Asthma History		
Seizure History		
Allergy/Anaphylaxis		

Care Plan Needed: Yes No



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Is your child currently diagnosed with or have a history of any of the following:

- ☐ Anxiety
- ☐ Asthma
- ☐ Allergies (seasonal, food, medication) If yes, please list:____
- ☐ ADD/ADHD
- ☐ Autoimmune Disease. Type:______________________________
- ☐ Behavioral Disorders
- ☐ Blood Disorders
- ☐ Cancer. If yes, please list type:__________________________ Remission: yes no
- ☐ Cavities or cracked/chipped teeth
- ☐ Chickenpox. If yes, list year:______________
- ☐ Chronic pain. Location:__________________
- ☐ Concussion
- ☐ Depression
- ☐ Diabetes
- ☐ Fainting/Syncope
- ☐ Frequent ear infections
- ☐ Frequent nose bleeds
- ☐ GI issues (irritable bowel, frequent constipation/diarrhea, pain)
- ☐ Head Trauma
- ☐ Hearing Loss
- ☐ Heart Disease or Congenital Heart Defect
- ☐ Kidney Disease or Frequent UTIs
- ☐ Meningitis. Type:_______________ Year of diagnosis:____________
- ☐ Respiratory Illness (frequent infections)
- ☐ Seizures. Type:_________________ Last Seizure:_______________
- ☐ Scoliosis or curvature of the spine
- ☐ Sickle Cell Disease
- ☐ Vision Loss. If yes, partial or full. Which eye?_____________
- ☐ Other:____
- ☐ Previous injuries (fractures):____
- ☐ Past Surgeries:____
- ☐ Previous Hospitalizations:____