Student Name _____ Grade _____ ID_____ YR 2016-2017

SINTON ISD STUDENT HEALTH INFORMATION-TO BE COMPLETED BY PARENT OR GUARDIAN

Home Address_____ Birth Date_____ Sex ☐ M ☐ F

City_____ Zip Code_____ Home Phone _____

EMERGENCY CONTACTS *(PERSONS WHO HAVE PERMISSION TO PICK UP STUDENT OR BRING MEDS)*

Mother/Guardian Name _____ Cell Phone _____
(circle one)
Place of Employment_____ Work Phone_____ EXT _____

Father/Guardian Name _____ Cell Phone _____
(circle one)
Place of Employment_____ Work Phone_____ EXT _____

Others: Name_____ Relationship_____

Phone: Home_____ Work_____ EXT _____ Cell_____

Others: Name_____ Relationship_____

Phone: Home_____ Work_____ EXT _____ Cell_____

General Physician_____ Phone_____

Physician Specialist_____ Phone_____

HEALTH PROBLEMS

Students are not allowed to carry medications while at school. No medication will be given at school without written permission.
Refer to the student handbook or school nurse for proper medication procedures and special circumstances.
Medication not picked up at the end of the year will be destroyed.
Students with a fever above 100 ^{o} F before taking medication should remain at home.

CONTACT NURSE DIRECTLY EACH YEAR REGARDING ALL SERIOUS MEDICAL CONDITIONS

Check yes or no to the following conditions as they apply to your student.
Chronic medical conditions such as asthma, seizures and diabetes require yearly management plans to be completed.
Explain symptoms, history, and treatment of other health problems in lines below, or on additional pages.
(Circle specific problem when indicated.)

HEALTH PROBLEM	YES	NO	HEALTH PROBLEM	YES	NO	HEALTH PROBLEM	YES	NO
ADD/ADHD (**Med Y / N**)	☐	☐	Down Syndrome	☐	☐	Orthopedic Problems	☐	☐
Arthritis- Juvenile	☐	☐	Eating Disorder	☐	☐	Pregnant (Due Date _)	☐	☐
Asthma (**Med at school Y / N**)	☐	☐	Headaches- Frequent/Severe	☐	☐	Psychological/Emotional Problems	☐	☐
Autism	☐	☐	Hearing Loss-Permanent/Aides	☐	☐	Seizures/Convulsions/Epilepsy	☐	☐
Birth Defects/Congenital	☐	☐	Heart Problems	☐	☐	Sickle Cell Anemia/Trait **(Circle 1)**	☐	☐
Blackouts/Fainting	☐	☐	Hemophilia	☐	☐	Substance Abuse		
Bladder Problems	☐	☐	Hypertension/High Blood Pressure	☐	☐	TB skin test ever showed Positive	☐	☐
Bowel Problems	☐	☐	Kidney/Renal Problems	☐	☐	Vision Loss-Permanent	☐	☐
Cancer/Malignancy	☐	☐	Intellectual Disability	☐	☐	Glasses/Contacts -Last exam __	☐	☐
Cerebral Palsy	☐	☐	Migraines per Dr. Diagnosis	☐	☐	**Hx of Chicken Pox** (Must sign form)	☐	☐
Cystic Fibrosis	☐	☐	Muscular Dystrophy	☐	☐			
Diabetes	☐	☐	Nosebleeds-Frequent/Severe	☐	☐	**Other Serious Medical Problems**	Specify below	

SIGNIFICANT ALLERGIES (Food/Drug/Insect/Other)_____
Symptoms_____ Treatment_____ Epipen ☐ Yes ☐ No

List All Medications and Treatments Required at School

Additional comments:

I give permission for school nurse or designated staff to contact the student's physician regarding health needs.

Parent/Guardian Signature_____**Date**_____

Office Use Only: Return to Campus Nurse