



# BAKER DEMONSTRATION SCHOOL

## Annual Health Services Survey 2010-11

Student Name: \_\_\_\_\_ Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_

As you know, good health is vital for an optimal learning experience. To provide the best care possible during school hours, the School Nurse asks that you please complete the following form to help us meet your child's health related needs. In addition, if you child has a special health need, the School Nurse will contact you to discuss his/her condition prior to the start of the school year so that medical information concerning a safe school routine can be efficiently passed on to teachers. If you have any questions, please contact the School Nurse at 847/425-5816. Thank you.

### ALLERGIES

What is your child allergic to? (Please include medication, environmental, food, seasonal allergies, etc.)

What is your child's usual or past reaction? \_\_\_ swelling \_\_\_ hives \_\_\_ rash \_\_\_ difficulty breathing/swallowing  
\_\_\_ other; explain: \_\_\_\_\_

What is the action to be taken in case of a reaction at school?

\_\_\_ Medication (list) \_\_\_\_\_ \*Please note: permission forms (found on our website or at the front office) for medication administration are required.

\_\_\_ Call Parent only

\_\_\_ Call EMS and parent immediately (applies for all Epi-Pen use) Does your child carry an Epi-Pen? \_\_\_ \*Epi-pens also need medication permission forms.

### ASTHMA

During the school year, how often does your child have attacks? \_\_\_\_\_

Causes of asthma attacks: \_\_\_ allergies \_\_\_ illness \_\_\_ weather \_\_\_ exercise \_\_\_ other; explain:

Usual symptoms: \_\_\_ wheezing \_\_\_ coughing \_\_\_ difficulty breathing \_\_\_ feeling of tightness in chest \_\_\_ other;  
explain: \_\_\_\_\_

Treatment for attacks; \_\_\_ rest \_\_\_ liquids \_\_\_ medications (list) \_\_\_\_\_

Does your child need to carry/self-administer an inhaler while in school? \_\_\_\_\_ \*Please note: permission forms (found on our website or at the front office) for medication administration are required.

### SEIZURE DISORDER

Type of seizure \_\_\_\_\_ Approximate date of last seizure or age at time of last seizure

\_\_\_\_\_ Average duration of seizures \_\_\_\_\_

Does your child take anti-seizure medication? \_\_\_ Name of medication(s) \_\_\_\_\_

List any special instructions for care during/after a seizure \_\_\_\_\_

### DIABETES

Age of diagnosis \_\_\_\_\_ Diet restrictions at school \_\_\_\_\_

Action to be taken for hypoglycemic reaction \_\_\_\_\_

Date of last serious reaction \_\_\_\_\_ Type of insulin used \_\_\_\_\_

Will student be performing blood sugar monitoring at school? \_\_\_\_\_

What are acceptable blood sugar parameters for your child? \_\_\_\_\_

### HEART CONDITIONS

Describe any heart problem \_\_\_\_\_

Describe any activity restrictions/medications \_\_\_\_\_

**OTHER HEALTH CONCERNS / OTHER MEDICATIONS NOT PREVIOUSLY LISTED** (Please include ADHD, any dental problems, orthopedic conditions, hearing aids, glasses, contacts, etc.)

\_\_\_\_\_

**Authorization:** I hereby authorize Baker Demonstration School health personnel to release my child's health information/records to teachers and administrators, for the purpose of treating, or preparing for, a medical situation for my child. This authorization is valid for one calendar year. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent.

Parent Signature

Date