Health Summary
2017-2018

COLUMBIA PUBLIC SCHOOLS

Administration Building • 1818 W. Worley Street • Columbia, MO 65203

SCHOOL_____ **GRADE**_____ **STUDENT #** _____

NAME_____ Male/Female_____Birthdate_____
PARENT/GUARDIAN #1_____ Home #_____Work #_____Cell #_____
PARENT/GUARDIAN #2_____ Home #_____Work #_____Cell #_____
EMERGENCY CONTACT_____/_____/_____
Name Relationship Phone #

DOCTOR/CLINIC_____ Phone# _____
DENTIST_____ Phone#_____
PREFERRED HOSPITAL_____
TYPE OF INSURANCE ☐Employment ☐Private Self-Pay ☐Straight Medicaid (red card) ☐MoHealthNet ☐None

☐**NONE OF THE HEALTH CONCERNS LISTED IN THE BOX BELOW APPLY TO MY CHILD**

MY CHILD HAS THE FOLLOWING SPECIAL HEALTH CONCERNS

☐**ALLERGIES:** (drugs, food, insects, pollens) Please list_____
Has allergy required emergency action in the past? ☐Yes ☐No Describe reaction: _____

A FOOD ALLERGY SUBSTITUTE REQUIRES A PHYSICIAN'S STATEMENT OF DISABILITY

☐**ASTHMA** ** **If yes, must complete Asthma History form****

☐**ATTENTION DEFICIT DISORDER (ADD/ADHD)**: Medications_____ Taken at: ☐Home ☐ School

☐**DIABETES:** ☐Insulin Dependent ☐Non-Insulin Dependent Physician: _____ Comments:_____

☐**EARS:** ☐ frequent infections ☐tubes (☐Right ☐ Left, date inserted _____) ☐hearing difficulty (explain)_____
☐hearing aid (☐Right ☐ Left, wear at school? ☐Yes ☐No) ☐other _____

☐**EYES:** ☐glasses (☐reading ☐distance) ☐contacts ☐ lazy eye ☐ difficulty seeing ☐previous surgery

☐**SEIZURES:** Describe seizure_____
Date of last seizure_____ Medication _____

☐**SICKLE CELL DISEASE:** _____ yes Physician: _____ Restrictions: _____

☐**OTHER MEDICATIONS:** _____Reason for taking _____ Taken at: ☐Home ☐School

OTHER HEALTH CONCERNS:
☐Bladder ☐bleeding ☐blood disorder ☐blood pressure ☐bowel ☐dental ☐eating ☐headaches
☐heart problem ☐lungs ☐menstruation ☐nosebleeds ☐neurologic ☐orthopedic ☐phobias(fears) ☐skin
☐sleeping ☐Other illness, injury or health problems which might affect performance at school_____
Explain: _____

☐**Requires Special Nursing Health Care (specify):** _____

☐**Check if you believe that because of the above stated impairment your child needs special education and related services under IDEA or Section 504 of the Rehabilitation Act.**

SPECIAL SERVICES STUDENT HAS REQUIRED OR IS RECEIVING: ☐IEP ☐Speech/Language ☐504 ☐OT/PT ☐Counselor

**** Copy of current immunization record must be presented to enroll ****

In accordance with the Board of Education policy, parents/guardians will be notified as soon as possible in case of serious illness or injury. Students given emergency care by school personnel as indicated in the Student Handbook. Parents/guardians who do not wish their child cared for in accordance with this policy should indicate this in writing to:
HEALTH SERVICES COORDINATOR; **1818 W. Worley, Columbia, MO 65203.**

My signature below verifies the above information to be accurate. I also permit the school nurse to share information with school staff as deemed appropriate by the nurse, to provide for my child's health and safety.

Signature of Parent/Guardian_____ **Date**_____

Revised 11/1/16

Asthma History

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Complete ONLY if student has asthma or history of asthma and return form to the school nurse.

Student_____ Student number _____ Grade _____ Height _____ Date _____

Triggers that might start an episode for this student? (check all that apply)

- ☐ Animal Dander
- ☐ Cigarette smoke, strong smells
- ☐ Cockroaches
- ☐ Dust Mites
- ☐ Emotions (when upset)
- ☐ Exercise
- ☐ Food Allergy
- ☐ Irritants
- ☐ Molds
- ☐ Pollens
- ☐ Respiratory Infections
- ☐ Temperature Changes
- ☐ Other _____

1. Does this student have a current prescription for any of the following medications to be taken daily to control respiratory problems? (check all that apply)
   - ☐ None
   - ☐ Advair®
   - ☐ Albuterol
   - ☐ Alvesco®
   - ☐ Asmanex®
   - ☐ Atrovent®
   - ☐ Dulera®
   - ☐ Pulmicort®
   - ☐ QVar®
   - ☐ Singulair®
   - ☐ Symbicort®
   - ☐ Theophylline
   - ☐ Tilade®
   - ☐ Xopenex®
   - ☐ Other _____

2. How many times in the last 3 years has this student required urgent or emergency care due to respiratory problems?
   ☐ Zero ☐ 1-2 ☐ 3-5 ☐ 6 or more

3. How many times in the last 3 years has this student been hospitalized due to respiratory problems?
   ☐ Zero ☐ 1-2 ☐ 3-5 ☐ 6 or more

5. Previous admission to Intensive Care Unit (ICU) for respiratory problems? Yes _____ No _____ Date: _____

6. How many days of school did this student miss last school year due to respiratory problems?
   ☐ Zero ☐ 1-2 ☐ 3-5 ☐ 6-9 ☐ 10 or more

7. What seasons of the year make this student's asthma symptoms worse? (check all that apply)
   ☐ Seasons do not affect asthma ☐ Fall ☐ Winter ☐ Spring ☐ Summer

8. Does this student recognize his/her early signs of worsening asthma? Yes _____ No _____

9. Approximately how often in a year does this student require the use of quick relief medicine, Albuterol (ProAir®, Proventil® or Ventolin®) or Xopenex®, to relieve respiratory problems?
   ☐ Zero ☐ 5 or fewer days per **year** ☐ 5 or fewer days per **month** ☐ 2 or fewer days per **week** ☐ more than 2 days per **week**

10. Does this student use more than 3 canisters of quick relief medicine per year? Yes _____ No _____

11. How many times in the last year was the student prescribed a systemic steroid (ex. Prednisone, Pediapred®, Orapred®, Medrol®) for treatment of an respiratory flare up?
    ☐ Zero to 1 ☐ 2-3 ☐ 4-5 ☐ 6 or more

12. How often does this student awaken during the night having difficulty with coughing, wheezing or breathing?
    ☐ Zero- 1 time/month ☐ twice/month ☐ 3-7 times/month ☐ 6 or more times/month

Medication plan for school (check all that apply)

- □ No medications at school/does not carry inhaler
- □ Inhaler for sports/extra-curricular only
- □ Student will carry quick relief inhaler during school hours (**Middle School and Senior High School students ONLY)**
- □ Quick relief inhaler to be kept in nurse's office
- □ Daily asthma medications to be kept in nurse's office
- □ Nebulizer tubing and medications to be kept in the nurse's office
- □ FEV1 or Peak Flow monitoring supplies to be kept in nurse's office

Columbia Public School's nurses recommend having an Asthma Action Plan for all students with asthma. Students who will be receiving asthma medications at school must have an asthma action plan on file. A form is available from the school nurse. If your physician has already developed an asthma plan, please provide a copy to the school nurse.

*****Please note: If your child has not used asthma medication in more than 3 years and no longer meets the criteria of persistent asthma, the health record may be changed to reflect 'history of asthma'. For questions, please contact your school nurse.**