Telluride Public School District
Health Inventory and Parent Information

Please fill out this form at the start of each school year
Please call the district school nurse Betsy Muennich RN at (970)369-7103 with any questions or concerns

GRADE: **SCHOOL:** THS ☐ **New student** ☐ **Returning**

Student Name: _____, _____, _____ (_____)
LAST FIRST MIDDLE NICK NAME

Date of birth: **Gender:** ☐ **M** ☐ **F** ☐ **Other:**

Parent/Guardian Name: **Phone:**

2nd Contact Name: **Phone:**

SECTION 1: PROVIDER INFORMATION

Doctor/Provider:	**Phone:**
Dentist:	**Phone :**
Optometrist:	**Phone:**
Orthodontist:	**Phone:**
Other:	**Phone:**
Date of Last Physical	

SECTION 2: HEALTH PROBLEMS/HEALTH ISSUES
Please check health problems your child has now – OR – has had in the past:

☐ **Check this box if NO changes from last year** or if your child does not have any medical issues. Please do not check if your child takes daily medications, has any chronic illnesses, new injuries like fractures – especially concussions, or recent surgeries or hospitalizations. It is important for the nurse's office to have an -to-date health history every year. **If you check this box, you can skip to Section 3.**

- ☐ Allergies (Section 5)
- ☐ Anaphylaxis (Section 5)
- ☐ Asthma (Section 5)
- ☐ Attention Disorder ADD/ADHD
- ☐ Birth weight less than 5 pounds
- ☐ Blood Disease
- ☐ Bone/Joint Disease
- ☐ Bronchitis – frequent
- ☐ Cancer
- ☐ Celiac disease
- ☐ Concussion/head injury (Section 5)
- ☐ Dental Issues/ Braces
- ☐ Developmental
- ☐ Diabetes/hypoglycemia (Section 5)
- ☐ Disabilities
- ☐ Eating/Weight Problems
- ☐ Ear Infections/Earaches
- ☐ Eczema
- ☐ Emotional Issues
- ☐ Gastrointestinal/Urinary
- ☐ Glasses/contacts
- ☐ Headaches
- ☐ Hearing Loss/hearing aids (Section 5)
- ☐ Heart Condition/blood pressure
- ☐ Immune problems
- ☐ Injuries - significant
- ☐ Intestinal/bowel issues
- ☐ Menstrual Issues
- ☐ Mental Health Issues
- ☐ Nose bleeds
- ☐ Phobias
- ☐ Pneumonia
- ☐ Seizures (Section 5)
- ☐ Skin problems
- ☐ Sleeping Problems
- ☐ Strep Throat- frequent
- ☐ Substance abuse issues
- ☐ Surgery/operations
- ☐ Vision
- ☐ Other:_____

If you have checked any of the above, please describe and explain:

SECTION 3: MEDICATIONS

Does your child take medications? ☐ Daily ☐ As Needed ☐ Prescription ☐ Over the Counter

Please List all medications: Include Medication Name, Dosage and Times given at home and/or at school:

1. _____
2. _____
3. _____

Does Your child need Medications at School? ☐ Yes ☐ NO

If yes, the Provider and Parent must sign the Permission to Give Medications at School Form.

EMERGENCY MEDICATIONS:

☐ **EPINEPHRINE AUTOINJECTOR** ☐ **INHALER** ☐ **BENADRYL**

☐ **SEIZURE MEDICATION** **OTHER:** _____

If your child is 12 years or older and you would like them to have over the counter medications if needed at school, please fill out the OTC Permission Form (English/Spanish).

SECTION 4: MEDICAL HISTORY

Has your child had chicken pox in the past? ☐ Yes ☐ No If yes -when? _____

Has your child had tuberculosis in the past? ☐ Yes ☐ No If yes -when? _____

Has your child had Covid-19 in the past? ☐ Yes ☐ No

Did they have any Covid complications? ☐ Yes ☐ No Number of vaccines: _____

SECTION 5: ADDITIONAL MEDICAL INFORMATION

If your child has any of the following issues, please fill out appropriate sections and forms.

Allergy & Anaphylaxis	**To Drugs, Food, Insects (include beestings), pollen, seasonal? Please list**: _____ _____ **Describe Reactions:** _____ • **Has the allergy required emergency action in the past?** ☐ Yes ☐ No • **Has the allergy caused difficulty breathing?** ☐ Yes ☐ No • **Does your child use an Epinephrine autoinjector?** ☐ Yes ☐ No • **Does your child have asthma?** ☐ Yes ☐ No **Note:** Self-carry contract is required for ALL students before carrying their own epinephrine. Only school nurses may approve. Also, have your child's provider fill out the Emergency Allergy & Anaphylaxis Care Plan if your child has severe allergy, anaphylaxis or requires an epinephrine autoinjector. Both you and your provider must sign. Contact the school nurse for information about our in-stock epinephrine emergency procedures.
Asthma	**Diagnosed by Doctor** _____

Reactive Airway

Date _____ **Last Episode** _____
Triggers: _____

Does Student Require medication to be given at School? ☐ Yes ☐ No
Does the Student Require a Spacer with an inhaler? ☐ Yes ☐ No

Note: Please have your provider fill out the Colorado Asthma Care Plan and provide a copy to the school nurse. Both you and your provider must sign.

- Grades 5 – 12 May self-carry inhaler IF approved by nurse and provider. Note: Self-carry contract is required for ALL students prior to carrying their own emergency inhaler.
- A back up inhaler for the Nurse's office is recommended. Contact the school nurse about our in-stock albuterol inhaler emergency procedure.

Diabetes Hypoglycemia

Date Diagnosed: _____

Paperwork (DMMP) from Barbara Davis Center (or other) to School Nurse? ☐ Yes ☐ No
Take Insulin? ☐ Yes ☐ No
Self-regulated? ☐ Yes ☐ No
Pump/self-inject? ☐ Yes ☐ No
Other: _____

Glucagon:
Self- carry? ☐ Yes ☐ No
In nurses room? ☐ Yes ☐ No
Extra Supplies to nurse? ☐ Yes ☐ No

Note: Contact Nurse for additional information

Dietary Nutritional Celiac

☐ **Celiac disease** ☐ **Lactose intolerance** ☐ **Gluten intolerance**	☐ **Food intolerance** _____ _____ ☐ **Food Allergy (go to Allergy)**	**Special considerations:** _____ _____ _____

Headache Migraine

Does your child require medication at school? ☐ Yes ☐ No
If yes, medication form filled out? ☐ Yes ☐ No
How frequently does your child get headaches? _____
Seen by doctor? _____

Additional Information: Migraine and Chronic Headache Care Plan (Children's Hospital Denver)

Head Injury Concussion

Has your child had a head injury/concussion? ☐ Yes ☐ No
If yes, when? _____ Number: _____
Does your child have any physical restrictions? ☐ Yes ☐ No
Academic accommodations? ☐ Yes ☐ No

Hearing Issues

☐ Known hearing loss ☐ Frequent infections ☐ Tubes ☐ 504 plan	☐ Hearing concerns: _____ _____ _____ ☐ Preferential seating	Hearing Aids: ☐ Yes ☐ No ☐ Right ☐ Left ☐ Other:_____

Heart Issues

Describe:_____
_____
List Physical Restrictions: _____

	Note: Please contact the school nurse for chronic health issues associated with your child's condition		
Seizure/Epilepsy	Describe: _____ Date last seizure: _____ Currently under doctor's care? ☐ Yes ☐ No Medications: _____ Required at school? ☐ Yes ☐ No **Note**: Please fill out the Emergency Seizure Action Plan and return to the school nurse.		
Special Services	Special Health Care: (explain) _____ _____	☐ Special Education Services ☐ Speech/Language _____ _____ ☐ OT/PT	☐ Counselor ☐ Title I ☐ Other: _____
Vision	☐ Glasses ☐ Contacts ☐ Preferential seating	☐ Reading ☐ Distance ☐ Difficulty seeing	☐ Injury ☐ Lazy eye ☐ Other:_____ _____

SECTION 6: HEALTH INSURANCE

Do you have health insurance for your child? ☐ Yes ☐ No

☐ **Private** ☐ **CHP+** _____ ☐ **Medicaid** _____

If your child does not have health insurance, do you grant the school district Nurse permission to share this information with Medicaid/CHP+ enrollment counselor? ☐ Yes ☐ No

If covered under Medicaid, do we have permission to bill for health-related services? ☐ Yes ☐ No

IMMUNIZATION AND INFECTIOUS DISEASE INFORMATION

Telluride School District Health and Illness Policy

How Sick is Too Sick: When to keep your child home or take them to the doctor – includes Covid-19 Guidelines:

- **Link available on TSD website under Health information; hard copies available nurse's office at both schools CDPHE's How Sick is Too Sick Guidelines (English/Spanish)**

IMMUNIZATION INFORMATION

Colorado Law requires students who attend a public-school grades kindergarten to 12th grade to be vaccinated against many of the diseases that vaccines can prevent unless there is an exemption form signed.

NOTE: If we do not receive appropriate paperwork at the start of the school year your child may be excluded from attending school.

The state requires certain immunizations and number of doses. In order to be compliant – your child must HAVE all the required immunizations for their age.

If they are in process or have a delayed schedule – they will need an non-medical exemption form

CDPHE School Immunization Resources

MEDICAL EXEMPTIONS

Have your provider fill out the following form. This form only needs to be filled out once unless information changes.

Medical Exemption Form in English/Exención médica en español

NON-MEDICAL/PERSONAL EXEMPTIONS

If your child has a religious, personal and/or non-medical exemption for all or one required immunization – or is on a delayed schedule - we must receive a download, paper copy, email, or fax of the exemption form prior to the start of school.

THERE ARE TWO WAYS TO SUBMIT A NONMEDICAL EXEMPTION

This must be filled out yearly prior to the start of school

TSD requires a printed copy of the Certificate of nonmedical exemption at the start of each year . If you submit to CIIS, the school can access the exemption information in CIIS, but cannot access the completed Online Immunization Education Module. You must bring or email (not confidential) to the health office.

NON-MEDICAL EXEMPTION FORM ENGLISH/FORMULARIO DE EXENCIÓN NO MÉDICA