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

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. We must receive either.

More Information for Immunizations that are required by the State of Colorado

MEDICAL EXEMPTIONS

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

NON-MEDICAL/PERSONAL EXEMPTIONS

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. If you submit to CIIS, the school can access the exemption information in CIIS, but cannot access the completed Certificate of nonmedical exemption

- Submit the Certificate of nonmedical exemption WITH a signature from an immunizing provider in Colorado who is a medical doctor, Doctor of Osteopathic Medicine, advanced practice nurse, delegated physician's assistant, registered nurse, or pharmacist OR
- Submit the Certificate of nonmedical exemption received upon completing ion of CDPHE's Online Immunization Education Module. Please send or bring a copy of this to the school nurse's office.
- Parents of students in preschool or childcare must submit nonmedical exemptions at 2, 4, 6, 12 and 18 months of age. These exemptions expire when the next vaccines are due or when the child enrolls in kindergarten.
- Parents of students in grades K-12 claiming a nonmedical exemption must submit one annually. Nonmedical exemptions expire June 30th each year. If you submit a Certificate of nonmedical exemption on or before June 30th, it will not be valid for the upcoming school year unless you submit the exemption during early registration.
- **Fill out the Non-medical/Personal Exemption Form and send it to the school nurse before the start of school. we do not receive**