NASHVILLE PUBLIC SCHOOLS

OFFICE OF THE SCHOOL NURSE

STUDENT HEALTH RECORD

Student Name ____ Sex __________ Grade ___________

School Year ______________ Race ___________________ Phone _____________________ ___________________

Address ____

Social Security Number (optional) _____________________________________Date of Birth ___________________

The student lives with: (Complete ALL information)

	Name	Place of Employment	Work Phone	Other Phone
Father				
Mother				
Other				

Please list two (2) OTHER people that we can contact if you cannot be reached, in case of sickness or emergency:

Name _______________________________ Phone ________________Relation to student _______________

Name _______________________________ Phone ________________Relation to student _______________

Please list other children in the household and their ages:

____

____

Please list any HEALTH PROBLEMS OR CONCERNS that might be necessary to know in order to adequately care for the student while in school:

____

____

Please list any allergies the student has:

____

IF NO REGULAR DOCTOR OR DENTIST, WRITE "NONE":

Student's doctor (Name, Address, Phone #) ____

Student's doctor (Name, Address, Phone #) ____

Other source(s) in which the student receives health care ______________________________________

HEALTH INSURANCE

Employee Insurance (Employer, Address, Phone #) ____

Private Insurance (Insurer, Address, Phone #) ____

Medicaid Insurance (Number) ____

Please answer the following questions about this student. (Yes or No, if yes, please explain):

1. Has this student had any serious illnesses, accidents or surgery? ____
2. Is this student presently on any medication? ____
3. Is this student under treatment for chronic illness such as allergy, convulsions, diabetes or heart disorder?

   ____
4. Has the student had any of the following diseases or conditions? Please check:

	Asthma		Mononucleosis
	Chicken Pox		Nervous Disorder
	Infectious Hepatitis		Strep Throat/Scarlatina or Rheumatic Fever
	Other (Please Explain):		

5. Does this student have any known drug or food allergies? ____
6. Have there been any indications of vision problems? (Sits too close to T.V., crossed eyes, poor eye contact when spoken to, etc.) ____
7. Have there been any indications of hearing problems? (Not startled by loud noise, does not respond to his name when back is turned, asks others to repeat what they said, freq. ear infections, etc.) ____________________
8. Has a doctor or public health nurse tested the student and found a hearing or vision problem? (if yes, please explain)____
9. Is the student's speech difficult for strangers to understand? ____
10. Has student shown any coordination problems in such activities as running, jumping, climbing, balancing, etc.?

    ____
11. Does student have any sleeping problems? (Getting to sleep, frequent waking up at night, etc.) ______________
12. Does student require frequent trips to the bathroom? ____

Is there any reason why this student's school Physical Education activities should be limited?

Yes _______ No _______ If yes, please send a doctor's statement explaining why and how it should be limited.

In case of minor accident, school personnel have my permission to administer first aid: Yes ________ No ________

In the occurrence of SERIOUS ILLNESS or LIFE THREATENING ACCIDENT when IMMEDIATE medical services are required, I give my permission for my child to be taken to the local Hospital Emergency Room for emergency care. I will assume any cost of ambulance transport if required or other costs of treatment for my child.

Yes _______ No _______ Local Doctor: ______________________________

Parent/Guardian signature required: ____