# HEALTH INFORMATION FORM

## 2020-2021

☐ **Copy to School Nurse**

TO BE COMPLETED BY PARENT OR GUARDIAN EACH SCHOOL YEAR

| **Student Name** Last, First, Middle | **School** | **Grade/Teacher** | ☐ **Male** ☐ **Female** | **DOB** |
|---|---|---|---|---|
| | | | | |

| **HEALTH CONDITIONS:** | ☐YES | ☐ NO | | ☐YES | ☐NO |
|---|---|---|---|---|---|
| ADD/ADHD | | | **Heart Condition | | |
| **Bleeding/Blood Disorder | | | **Physical Disability | | |
| **Cancer | | | Bladder/Bowel Issues | | |
| Anxiety/Depression Disorder | | | **Other | | |

| **Vision:** | ☐ Glasses | ☐ Contacts | ☐ Other | Hearing: | ☐Hearing Loss | ☐Hearing Aid |
|---|---|---|---|---|---|---|

| **ALLERGIES: Check Type of Allergy and Reaction Type** | |
|---|---|
| ☐Food | Name of Food(s): |
| ☐Medication | Name of Medication(s): |
| ☐Insect Sting | Type of Insect(s): |
| ☐ Other (List) | Type of Allergy: |

| **ASTHMA :** | ☐Mild | ☐Moderate | ☐Severe |
|---|---|---|---|

| ☐**Current Medication/Treatment:** | ☐Inhaler | ☐Oral Medication (pills) | ☐None |
|---|---|---|---|

| **DIABETES:** | | | |
|---|---|---|---|
| ☐**Type 1** | ☐Insulin Pen | ☐Insulin Pump | ☐ Continuous Glucometer |
| ☐**Type 2** | ☐Oral Medications: (Pills) | | |

| **SEIZURE DISORDER:** | Date of last seizure: | |
|---|---|---|

** IF you Answered **YES** to any of the **Above**, please tell us more _____

_____

1. What Medications does your child take daily at home? _____
2. What Medication will your child take at school? _____

## PART 3 EMERGENCY AUTHORIZATION

- **I, the undersigned, do hereby authorize any designated employee of the Enid Public Schools to contact directly the persons named on this form and do authorize the above named physician to render such treatment as may be deemed necessary in an emergency, for the health of above named child.**
- **In the event that physicians, other persons named on this form, or parents cannot be contacted, any designated school employee is hereby authorized to take whatever action is deemed necessary in their judgment, for the health of aforesaid child.**
- **I will not hold the school district financially responsible for the emergency care and/or transportation for said child.**
- **I give permission for the above health information to be released to school personnel necessary to ensure my child's health and safely while at school.**
- **I hereby authorize the Oklahoma Immunization Service to release my child's immunization records and information located within the Oklahoma State Immunization Information System ("OSIIS) to Enid Public Schools as needed to verify my child's immunization status. This consent is valid for the duration my child is enrolled in Enid Public Schools.**

| **Father:** | **Cell Phone** | **Father Work Place** | **Father Work Phone** |
|---|---|---|---|
| | | | |
| **Mother:** | **Cell Phone** | **Mother Work Place** | **Mother Work Phone** |
| | | | |
| **Health Care Provider Name/Phone Number** | | **Hospital Preference** | |
| | | | |
| **Emergency Contact #1** | **Cell Phone** | **Work Phone** | |
| | | | |
| **Parent Signature:** | | | |
| | | | |