

EAST UNION COMMUNITY SCHOOLS

Health Related Services

Annual Health Information -- TK-12

Student Name _____ Birth Date _____ Sex _____
Grade/Room _____ School attended last year _____

HEALTH CONCERNS

Please put an (X) if your child has any of these health concerns:

- No health concerns
- ADHD/ADD
- Allergies (to what?) _____
- Asthma or other breathing problems
- a. Has your child ever been diagnosed by a doctor as having asthma? Yes No
- b. Has your child had episode(s) of wheezing (whistling in the chest) in the last 12 months? Yes No
- c. In the last 12 months have you heard your child wheeze or cough after active playing? Yes No
- d. Other breathing problem (describe) _____
- Bladder problems/Bowel problems (describe) _____
- Chickenpox (list month and year he/she had disease) _____
- Diabetes: Type 1 Type2 (Managed by: Diet only Oral Med)
 Insulin Injections Insulin pump
- Heart Problems (describe) _____
- Seizures: Type (describe) _____
- Social/emotional/behavioral/mental health concerns (describe) _____
- Other health concern of significant history of problems (describe) _____
- Activity restrictions: (describe) _____
- Any surgeries or hospitalizations? Yes No If yes, explain _____

EMERGENCIES: Does your child have a health problem that could result in an emergency? Yes No
If yes, describe: _____

MEDICATIONS: List **ALL** medications that your child takes every day or when needed. A consent is **REQUIRED** for **ALL** medications taken at school. **A new consent is needed each school year.** Forms are available in the health office.

Medication Name	Purpose	Dose	How often taken?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

VISION

- No vision problems
- Glasses/contacts prescribed
- Wears glasses/contacts all of the time
- Wears glasses in classroom only
- Glasses lost/broken
- Has (or has had) glasses but does not wear
- Other (describe) _____

HEARING

- No hearing problem
- Frequent ear infections (more than 3 per year)
- Has ear tube(s) Date inserted _____
- Hearing loss right ear left ear
- Hearing aid(s) right ear left ear
- Aids lost/broken
- Has (or has had) aids but does not wear
- Other (describe) _____

DENTAL

By checking this, I give permission for the **I-Smile** program to provide a dental screening, @ NO CHARGE, if needed, by a registered dental hygienist. This oral screening does not take the place of your child's regular visit to the dentist, but it does satisfy the Iowa school mandate audit.

HEALTH INSURANCE

- My child has health insurance: If yes, what kind _____
- My child has no health insurance

HEALTH CARE PROVIDERS:

Does your child have a doctor or clinic where they usually go for health care? Yes No

If there is no family physician, will the choice made by the school be satisfactory? Yes No

Hospital preference: _____

Name of Doctor or Clinic	Location and Phone	Approximate Date of Last Exam
Primary Health Provider (regular doctor)		
Eye Specialist		
Ear Specialist		
Dentist		
Other Specialist (specify type)		

Comments:

This health information may be shared with East Union school staff as needed. If you do not want this health information shared, please contact the school nurse.

Parent/Guardian Signature: _____ Daytime Phone: _____

Print Parent/Guardian name: _____ Today's Date: _____