

DENISON HIGH SCHOOL HEALTH INFORMATION & CONSENT FORM

Student's Name (first, middle, last) _____ Age _____ Grade _____

Address _____ Home Phone _____

Student's Social Security Number _____ Birthdate _____

Country of Birth _____ Date Entered U.S. _____ Entry Date into District _____

Mother's Name & Address _____ Phone _____

Mother's Place of Employment _____ Phone _____

Father's Name & Address _____ Phone _____

Father's Place of Employment _____ Phone _____

Guardian's Name & Address _____ Phone _____

Guardian's Place of Employment _____ Phone _____

Parents/Guardians' Marital Status: Single _____ Married _____ Divorced _____ Separated _____

Parent/Guardian(s)' Cell Number _____

NON-ENGLISH SPEAKING HOUSEHOLDS: Do you prefer communications in **English** or **Spanish** (Circle One).

IN CASE OF EMERGENCY OR ILLNESS list responsible people, other than parent/guardian, who can be contacted:

1. Name & Address _____ Phone _____

2. Name & Address _____ Phone _____

If Foster Student, In-Home Provider's Name and Telephone Number: _____

JCO's Name and Telephone Number: _____

DHS Case Manager's Name and Telephone Number: _____

Do you have a doctor? Yes _____ No _____ Name/Address/ Phone _____

Do you have a dentist? Yes _____ No _____ Name/Address/ Phone _____

Did your child have an **injury, illness, or accident** this summer or last year? If so, please state the type and date of:

Does your child have seizures? Yes ___ No ___ Allergies? _____

Does your child have **asthma**? Yes ___ No ___ **If yes, please complete the form on second page.**

Is your child receiving treatment for any current health condition? (diabetes, heart disease, seizure disorder, etc.)

Yes _____ No _____ State condition/treatment: _____

Has your child had any operations? Yes _____ No _____ State type/date: _____

Is your child taking any medications (including inhalers)? Yes _____ No _____ If yes, list name & dosage:

IF YOUR CHILD IS TAKING PRESCRIPTION MEDICINE AT SCHOOL, THE MEDICINE MUST BE KEPT IN THE NURSE'S OFFICE.

Has your child been out of the United States more than 30 days in the past calendar year? Yes _____ No _____

Did your child receive immunizations this past year? Yes _____ No _____ (Include tetanus booster)

If yes, give the name, month, date, year & doctor/clinic: _____

Does your child wear glasses? Yes _____ No _____ and/or contacts? Yes _____ No _____

Does your child have permission to take Acetaminophen/Tylenol/Tums/Cough Drops/Eye Drops/Ibuprofen/Antibiotic Ointment at school? Yes _____ No _____

Does your child have permission to have hearing/vision/spinal/dental screenings at school? Yes _____ No _____

Father's Signature _____ Date _____

Mother's Signature _____ Date _____

Guardian's Signature _____ Date _____

If you checked that your child has asthma, please fill out the school asthma record below. This information will be shared with the appropriate staff such as classroom teachers, P.E. teacher, and coaches.

Please let us know of changes in your child's asthma or medication schedules. Contact the school nurse if you have any questions.

SCHOOL ASTHMA RECORD

Student name _____ Grade: _____

Parent's name _____ Date: _____

Physician treating child's asthma _____ Phone: _____

Asthma Triggers (What causes an asthma episode)

_____ Exercise _____ Animals _____ Strong odors/perfumes
_____ Respiratory infections _____ Dust _____ Pollens _____ Molds
_____ Change in temperature _____ Foods _____ Other _____

Comments: _____

Current Medications:

Name	Dose/Amount	When to use
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medications to be taken at School: *(Include inhalers)*

Name	Dose/Amount	When to use
_____	_____	_____
_____	_____	_____

Sports student involved in: _____

Asthma Emergency Plan:

Possible signs of an emergency are:

- Trouble breathing, walking or talking
- Lips or fingernails are gray or blue
- No improvement after initial treatment with medication, symptoms worse

Action to be taken:

- Notify school nurse
- Contact parent/guardian or physician
- Seek emergency medical care (911)

Comments/Special instructions: _____

Inhalers at school:

_____ has been instructed on the proper way to use inhalers and I give permission for my child to carry the inhaler with him/her and use as needed. _____ Yes _____ No

I request that my child keep the inhaler in the school/nurse's office. _____ Yes _____ No

Parent Signature

Date