**Des Moines Public School Annual Health Review (Middle and High School) School Year \_\_\_\_\_\_**

**Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**HEALTH REVIEW: Allergies:** Food \_\_\_\_\_\_\_\_\_\_\_\_\_Medicine \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Environmental \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medication Taken to Treat \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Breathing Problems Heart Problems Neurologic Problems Eating Problems Gland Problems Orthopedic**

**\_\_\_** Asthma \_\_\_Heart Murmur \_\_\_Frequent Headaches \_\_\_ Stomach Problems/Ulcer \_\_\_ Diabetes \_\_\_ Broken Bones

\_\_\_ Reactive Airway \_\_\_Heart Surgery \_\_\_Dizziness \_\_ Fainting \_\_Seizure \_\_\_ Bowel Problems \_\_\_ Thyroid \_\_\_ Orthopedic Braces

**\_\_\_**Other Problem\_\_\_Other Problem\_\_\_ ADHD/ ADD \_\_\_ Special Diet at School \_\_\_ Other Problem \_\_\_Other Problem

\_\_ Recent Illness \_\_\_ Recent injury \_\_\_Recent surgery If checked please describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **List any emotional, social, or other conditions that might affect your child’s school performance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**List other health concerns you would like the nurse to know about: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Current Medications \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medications Given at School \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Dr. Ordered Needs** \_\_\_Glasses/ Contacts \_\_\_Hearing Aids \_\_ Seat Close to Instruction Extra Bathroom Access for \_\_\_ Bowel \_\_ Bladder \_\_\_ Physical Education Limits

**International Travel:** **My child has been outside the United States during the past year. \_\_\_Yes \_\_\_No Name of Country:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PARENT AUTHORIZATIONS: Please read and give consent by signing each statement**

**Over The Counter Medications In Middle and High Schools:**

**I give permission to the school nurse to give my child an age appropriate dose of Acetaminophen (Tylenol) or Ibuprofen (Advil) when needed-Up to 5 total doses/ school year without a Dr. order. \*\*Cough Drops and Chapstick:** Will be allowed in class - Individual teachers may refuse the privilege if misused.

**\*\*\*\*PARENT SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Health Information: I give permission to the school nurse to share educationally relevant health and emergency information (to include medical diagnosis) with school staff on a need to know basis.**

**\*\*\*\*PARENT SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Health Insurance Information:**  \_\_\_ Private \_\_\_Medicaid \_\_\_ hawk-i \_\_\_No Insurance \_\_\_\_ **I give permission for the nurse to contact me about health insurance options or refer to an appropriate community agency for health insurance assistance**

**\*\*\*\*\* PARENT SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Emergency Information: Doctor Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hospital of Preference: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Parent Contact Numbers: Mother Name \_\_\_\_\_\_\_\_\_\_\_\_Phone: Home/Cell\_\_\_\_\_\_\_\_\_\_\_\_\_ Work\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E Mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Father Name Phone: Home/Cell\_\_\_\_\_\_\_\_\_\_\_\_\_ Work\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E Mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**