Bluffton-Harrison MSD
Student Health Information 2016-2017

***Please complete both sides**

Student name: _____ Grade _____ Birth date _____
Physician _____ Phone _____

Medical History/Conditions

For each of the following conditions please circle "Yes" or "No". For "Yes" answers, please list any medications taken or any special care for the condition. If needed, please use the back of this page for additional information. If the student takes any medication, please fill out the medication section on the back of this page.

	Condition	Yes/No	Medication/Special Care/Notes
1.	Acid reflux/GERD/frequent vomiting	Yes/No	_____
2.	ADD/ADHD (Attention Deficit Hyperactivity Disorder)	Yes/No	_____
3.	Bone, joint, or muscle disorders/fractures	Yes/No	_____
4.	Bladder or Kidney concerns/control problems	Yes/No	_____
5.	Bowel concerns (constipation, loose stools)	Yes/No	_____
6.	Ear or hearing concerns	Yes/No	_____
7.	Emotional/psychological	Yes/No	_____
8.	Eye or vision concerns	Yes/No	_____
9.	Genetic disorder/Chromosome disorder/Syndrome	Yes/No	_____
10.	Heart/Congenital Heart Defect/Heart Surgery	Yes/No	_____
11.	Headaches (frequent, migraines, sinus)	Yes/No	_____
12.	Medical Equipment (feeding tube, wheelchair, etc)	Yes/No	_____
13.	Pollen, dust, environmental allergies	Yes/No	_____
14.	Shunt/hydrocephalus	Yes/No	_____
	Please see nurse if you answer YES to any of the below:		
15.	Asthma	Yes/No	_____
16.	Autism Spectrum Disorder	Yes/No	_____
17.	Bee /Insect sting allergy*	Yes/No	_____
18.	Cerebral Palsy (C.P.)/Neurological disorders	Yes/No	_____
19.	Diabetes (If yes, please see nurse for school instructions)	Yes/No	_____
20.	Digestive concerns/special diet/tube fed	Yes/No	_____
21.	Epilepsy/Seizure disorder	Yes/No	_____
22.	Food allergy**/Intolerance (milk, dairy products, etc.)	Yes/No	_____

Allergies

Please list the type of reaction and medication/treatment needed for each allergy:

Allergy	Type of Reaction	Medication/Treatment Needed
_____	_____	_____
_____	_____	_____
_____	_____	_____

***If emergency medications are needed for allergies, please fill out a "Medication Authorization Form" and bring the medication to school in the original container.**

****If the student has a food allergy or needs food substitution in the school cafeteria, a doctor note is required.**

Please complete the back side of this form.

Medications
Does this student take any medication (prescribed and/or over-the-counter/OTC)? Yes/ No

Medication Name	**Dose and Time(s) Taken**	**Reason for Medication**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Most medications may be taken at home. Will this student need to take medication **during school hours?***
Yes/No Explain: _____

***Note: BHMSD policy requires all medication given to students to be supplied by the parent/guardian. All medication must be in the original container. Prescription medication given at school requires a medication permission form signed by the physician and parent/guardian. Over the counter medication (i.e. pain relievers) must have a medication permission form signed by the parent. Herbal supplements require a prescription by a physician and an authorization form. All forms are available from the school nurse and on the school website.**

Immunizations
Has the student received any immunizations in the past year? Yes/No List new: _____
In order to keep the student's immunization record up-to-date, be sure to give a copy of any new immunizations, with dates, to the nurse.

Vision Exams
Has the student been seen by an optometrist (eye doctor) in the past year? Yes/No (If yes, please have the optometrist fill out a vision exam report and turn it in to the school nurse. See the nurse if you need a form.)

Recent injuries/Fractures/Surgeries/Hospitalizations
Please list any recent injuries, fractures (broken bones), surgeries, or hospitalizations with dates:

_____

_____

Other information
Please give any additional information that would be helpful for the staff at school to know to keep the student safe and healthy:

_____

_____

To ensure the care of my child, I give the school nurse permission to share pertinent health information about my child with appropriate school staff. This will be done only on a "need to know" basis and in a confidential manner. I agree that the school nurse may consult with my child's family doctor/health care provider(s) about the medical conditions on this form. I agree to alert the school nurse and my child's teacher, in writing, of any change in my child's medication and/or health status. The above permission will be valid through June 2015, unless I revoke the permission in writing.

Parent/Guardian Signature_____ **Date** _____

Student's Full Name_____

Please complete and return by the second day of school.