Sturgis Charter Public School

An International Baccalaureate Diploma School

Health History and Emergency Medical Form for New Students

Please answer the following questions regarding your child's health status and medical information to the best of your ability. This information will be reviewed by the school nurse and kept confidential.

Student's Name: _____ **Date of Birth**: _____
Grade: _____ **Date of Entrance**: _____ **Previous School**: _____
Parent(s)/Guardian(s): _____
Address:_____
Primary Telephone (home, work, or cell): _____ **Alternate**: _____
With whom does he/she live? _____
Primary care physician name: _____**Telephone**: _____
Dentist's name: _____**Telephone**: _____
Date of last physical exam: _____ **Date of last dental exam**: _____
Medical Insurance Company: _____
Plan/Policy Holder: _____ **Plan/Policy Number**: _____
□ Please check here if your child does not currently have health insurance and you would like to speak with the school nurse for more information on attaining health insurance coverage.
Has he/she sustained any recent injuries requiring physician's treatment? If yes please explain:

_____

Has he/she had any recent hospital visits? If yes please explain:

_____

Has he/she ever had a concussion? ____ Yes ____ No, If so when: _____
What medication if any does he/she take regularly?

_____

Note: please see the Sturgis Charter Public School medication policy.

Please list any allergies he/she has, type of reaction, and usual treatment:

_____

Does he/she have a history of substance abuse (including alcohol, tobacco, caffeine, inhalants, pills, marijuana or other street drugs)**? ____ Yes ____ No**
If yes please indicate the substance(s) and how it was/is being addressed:

_____

Does he/she have a history of eating disorders (i.e. anorexia or bulimia)**? ____Yes ____ No**
If yes please indicate how it was/is being addressed:

_____

Is there anyone concerned with his/her eating habits? ____ Yes ____ No. If yes please explain:

_____

Does he/she have a history of mental health issues? ____ Yes ____ No
Please indicate mental health issues/concerns: _____
Has he/she been hospitalized for mental health concerns? ____ **Yes ____ No When?** _____
Any history of suicidal ideation or suicide attempt? ____ **Yes ____ No When?** _____
Is he/she currently in counseling? ____ Yes ____ No Counselor's Name: _____
Does he/she seem to: ____ Cry often ____ Get easily upset ____ Be angry often
____ Be Troubled/worried ____ Be Unhappy ____ None of the above

Has he/she experienced any major changes in family life this past year (i.e. moving, divorce, loss of a close friend/relative, close friend/relative with serious illness, birth or adoption of a sibling or close family member, marriage of a parent)**? ____ Yes ____ No, If yes what:**_____

Please check any health conditions/concerns:

____ Asthma ____ ADD/ADHD ____ Anxiety ____ Cardiac Conditions ____ Chronic Strep Throat
____ Depression ____ Diabetes ____ GI Problems ____ Frequent Headaches ____ Lyme Disease
____ Mononucleosis ____ Painful Periods ____ Pneumonia ____ Seizure Disorder ____ Scoliosis
Other: _____

Does he/she wear glasses/contacts? ____ Yes ____ No, Date of last eye exam: _____

Any vision or hearing concerns?_____

Does he/she have any present limitations (physical or academic) requiring program modification or restrictions? ____ Yes ____ No If yes, please explain: _____

Are any of his/her family members in the military? ____ Yes ____ No, Who? _____

Current Height: ____ Feet ____ Inches Weight: _____ Lbs.

Emergency Contacts:

Name: _____Phone with area code: _____

Relationship to student (i.e. friend of parent, neighbor, Aunt etc.)**: _____**

Name: _____Phone with area code: _____

Relationship to student (i.e. friend of parent, neighbor, Aunt etc.)**: _____**

Non-Prescription Medication Consent: The school nurse may assess and administer up to seven doses of the following over the counter medications to my child during the school year; Tylenol (acetaminophen) 325 mg-650 mg (1-2 tablets) every 4-6 hours, Motrin (Advil/ibuprofen) 200 mg-400 mg (1-2 tablets) every 6-8 hours, Cough drops 1-2 as needed, and Tums (calcium carbonate) 500-1000 mg (1-2 tablets) as needed. I understand I will be notified if my child exceeds the seven dose limit and asked to sign and return the Non-Prescription Medication Consent and Order form to the school nurse.

□ **By checking here** I give my consent for medication administration to my child and agree to all of the conditions listed above.

Parental Releases:

1. By signing below I agree that the above information has been completed to the best of my ability.
2. By signing below I acknowledge that I have read and understand both the medication and physical exam policy of Sturgis Charter Public School.
3. By signing below I agree that although my child's health information is confidential, it may be shared on a need to know basis with my child's medical providers, including substitute nurses, and school staff. A copy of this information may be given to a school staff member accompanying my child on a field trip or school outing. A copy of this information will be given to EMS in the event of an emergency.
4. By signing below I, _____ (parent/guardian name), understand that in case of illness or injury to my child, _____ (child's name), the school will make every effort to notify me or the emergency contact I have listed above. In the event that emergency medical care is necessary and I cannot be reached, I grant full power to Sturgis Charter Public School to contact emergency medical services and/or arrange transportation to the nearest medical facility for treatment and sign releases as required by the medical facility to obtain any medical or surgical treatment in the judgment of medical authorities at the facility.

Parent/Guardian Name (Printed): _____

Signature: _____ Date: _____