DIOCESE OF TUCSON CATHOLIC SCHOOLS

HEALTH SERVICES REGISTRATION Pre-K - 12

Student's Name: ______________________ (Last / First / Middle) **Date of Birth:** __________ **Grade:** ______

HEALTH CONCERNS/HEALTH HISTORY:

☐ ⟵ Check here if your child **DOES NOT** have any health issues *(sign at bottom)*

☐ If your child has health concerns please check all current health conditions below and fill in blanks if applicable.
Parent/guardian is responsible for notifying the school of new or existing health concerns and for providing the school with any medication or equipment that the student will require during the school day. Check with the health office to obtain the correct procedural forms. ***Life-threatening conditions such as anaphylaxis, asthma, diabetes, or other conditions require individual health care plans/action plans, medication permits, and staff training prior to the first day of school. Please contact the school nurse to discuss your child's needs.***

☐ ALLERGIES *(*requires an Allergy Action Plan if intervention is needed at school and a medication permit if medication will be kept in health office)*

☐ Food: __________ ☐ Bee / ☐ Insect: __________ ☐ Allergy to Medication: __________ ☐ Other: __________

School Treatment: ☐ My child will carry EpiPen *& has been instructed on EpiPen use* ☐ EpiPen will be kept in Health Office* ☐ Other: __________

☐ ASTHMA *(*requires an Asthma Action Plan if intervention is needed at school and a medication permit if medication will be kept in health office)*

Triggers: ☐ Exercise ☐ Environmental ☐ Other: __________

School Treatment: ☐ My child will carry inhaler *& has been instructed on inhaler use* ☐ Inhaler/Nebulizer will be kept in health office*

☐ My child was diagnosed with asthma but no longer uses an inhaler - date of last asthma episode: __________

☐ DIABETES *(*a Diabetes Care Plan is required for all students with Type I Diabetes - please contact the school nurse prior to the start of school)*

☐ *Type I (takes insulin) ☐ Insulin Pump ☐ Pen ☐ Syringe ☐ Type II (diet/exercise/medication controlled)

☐ EMOTIONAL/BEHAVIORAL/PSYCHOLOGICAL/DEVELOPMENTAL

☐ ADD ☐ ADHD ☐ Anxiety ☐ Asperger's ☐ Autism ☐ Bipolar ☐ Depression ☐ Developmental Delay

☐ Mood Disorder ☐ OCD ☐ ODD ☐ PTSD ☐ Schizophrenia ☐ Other: __________

☐ HEARING/VISION

☐ Known hearing loss *explain:* __________ ☐ Hearing aid ☐ Glasses/Contacts ☐ Other vision problem: __________

☐ MOBILITY/ACTIVITY

☐ Activity restriction *explain:* __________ ☐ My child uses an assistive device: ☐ Wheelchair ☐ Walker ☐ Other: __________

☐ SEIZURES *(*please contact the school regarding a seizure action plan and a medication permit if medications will be given at school)*

Type of seizure: __________ ☐ Date of last seizure: __________ ☐ My child will have Diastat at school*

☐ OTHER MEDICAL ISSUES *(if you check any conditions below please explain in space provided)*

☐ Bleeding disorder ☐ Birth defect/disorder ☐ Cancer ☐ Cerebral Palsy ☐ Concussion (date: ______) ☐ Endocrine

☐ Gastrointestinal/Bladder ☐ Skin condition ☐ Heart Condition ☐ Hypertension ☐ Migraines ☐ Other: __________

Explanation: __________

☐ My child will need help with activities of daily living and/or health care procedures *(*contact nurse)*

☐ MEDICATION *(*obtain medication permit from health office at school)*

Medication taken at home: __________

☐ Medication to be given at school *(*permit required)*: __________

Information provided on this form will replace and/or update any previous health information received with the exception of Life-Threatening Health Conditions *(contact nurse about removing this information)*. It is the parent/guardian responsibility to notify the health office if any changes occur in their child's health status.

Parent/Guardian Name (printed): __________ Parent/Guardian Signature: __________ Date: __________