ONEIDA NATION SCHOOL SYSTEM

HEALTH FORM

In an effort to ensure that every child receives the best care while at school, we are asking every parent to answer health-related questions about their child. By being aware of the health conditions or medications your child has, we can be better prepared to help make your child's school time successful, safe and healthy. **Please complete one form per child.**

Name:	**Birthdate:**	**Grade:**

ALLERGY INFORMATION

Does your child have ALLERGIES? (type: Seasonal, Food, Medication, Insects)	**Yes** ☐	**No** ☐

Allergies

☐ Food	Specify:	**Does your child require emergency epinephrine:** ☐ **Yes** ☐ **No**
☐ Insect	Specify:	Does your child require oral antihistamine? ☐ Yes ☐ No
☐ Seasonal	Specify:	

MEDICAL and HEALTH CONDITIONS

Does your child have a chronic medical or health condition?	**Yes** ☐	**No** ☐

Has your child been diagnosed with any of the following conditions by a Healthcare Provider (check all that apply)? ***Is this a change from last school year?*** ***☐ Yes*** ***☐ No***

☐ ADD/ADHD ☐ Emotional/Behavioral/Psych ☐ Heart Condition: _____
☐ Asthma ☐ Headaches/Migraines ☐ Epilepsy/Seizures
☐ Diabetes ☐ Orthopedic ☐ Other _____

Details/Specifics regarding condition:

MEDICATIONS

MEDICATION: Is your child currently taking any medication? ☐ **Yes** ☐ **No**

Type of medication:	Reason for medication:	When is it given?

If your child uses an **inhaler**, do they **carry it with them**? *For elementary and middle school students, please discuss self-carry with school nurse*	**Yes** ☐	**No** ☐
If your child is on **nebulizer treatments**, do they need to have a **supply at school**?	**Yes** ☐	**No** ☐

ADDITIONAL INFORMATION

Has your child had hearing testing or been recommended to have one completed?	**Yes** ☐	**No** ☐
Does your child wear corrective lenses (Glasses or Contacts)?	**Yes** ☐	**No** ☐
Has the student received vaccines outside of WI? *If yes, please provide records*	**Yes** ☐	**No** ☐

_____ **Please INITIAL to verify understanding:** *The School Nurse, employed by the Oneida Comprehensive Health Division, does have access to your child's health records at the Oneida Community Health Center.*

Parent/ Guardian Signature: _____ **DATE:** _____

For office use: Initials _____ Date Received _____ F/U: Yes No Start Date _____