# ONEIDA NATION SCHOOL SYSTEM

*From the Office of the School Nurse*

# HEALTH FORM

Child's name: Date of Birth: Grade:

## ALLERGY INFORMATION

Does your child have any of the below ALLERGIES? If yes, does your child require: ☐ epinephrine ☐ oral antihistamine

| Food Allergens | Specify | Accommodations/Alternatives | Environmental Allergens | Specify |
|---|---|---|---|---|
| ☐ Milk / Dairy | | ☐ Yes: | ☐ Pollen | |
| ☐ Eggs | | ☐ Yes: | ☐ Dust Mites | |
| ☐ Peanuts | | ☐ Yes: | ☐ Animal Dander | |
| ☐ Tree Nuts | | ☐ Yes: | ☐ Mold | |
| ☐ Soy | | ☐ Yes: | ☐ Insects | |
| ☐ Wheat | | ☐ Yes: | ☐ OTHER | |
| ☐ Fish, Shellfish | | ☐ Yes: | ☐ Medication Allergens | |
| ☐ OTHER | | ☐ Yes: | Specify: | |

## MEDICAL and HEALTH CONDITIONS

Has the student received vaccinations outside of WI? ☐ **No** ☐ **Yes, State:** _____ *(please submit the records)*

Does your child wear corrective lenses [glasses or contacts]? ☐ **No** ☐ **Yes**

Has your child had hearing testing or been recommended to have one completed? ☐ **No** ☐ **Yes**

Has your child been diagnosed with any of the following conditions by a Healthcare Provider? ☐ **No** ☐ **Yes**

☐ ADD/ADHD ☐ Emotional/Behavioral/Psych ☐ Heart Condition: _____
☐ Headaches/Migraines ☐ Epilepsy / Seizures ☐Nebulizer: is supply needed at school? ☐ **Yes** ☐ **No**
☐ Diabetes ☐ Orthopedic ☐ Auditory: does the student use Hearing Devices?☐ **Yes** ☐ **No**
☐ Asthma ☐ Vision _____ ☐ Other _____

If your child uses an inhaler, does student self-carry inhaler:
☐ **Yes** ☐ **No** *(students in grades K-8, please discuss self-carry with School nurse)*

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

| Type of medication | Reason for medication | When is it given? |
|---|---|---|
| | | |
| | | |
| | | |

**If medication will be administered at school**, the medication(s) and delivery must: 1) be delivered by a parent/guardian, 2) be in the original medication container, 3) have an attached signed parent authorization consent form, and 4) if the medication requires a prescription, it must be able to be verified by the prescribing licensed professional.

Name of medical facility where child receives healthcare: _____
Provider's name and phone number: _____

_____ **Please INITIAL to verify understanding**: *The School Nurse, employed by the Oneida Comprehensive Health Division, has access to my child's health records at the Oneida Community Health Center. I understand my child's teachers will receive communication regarding my child's health and medical needs or requirements.*

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