Mandatory

Oak Park Unified School District
Student Daily Health Information and Medical History
2019-2020 School Year

Student Last Name _____ **First** _____ **Middle** _____ **M / F** _____ **Grade** _____

Birth Date _____

MEDICAL HISTORY: *Please check if student has history of the following diseases or conditions*:

☐ Asthma	☐ Diabetes	☐ Seizure Disorder
☐ Allergies	☐ Heart Condition	☐ Migraines
☐ Frequent Headaches	☐ Intestinal Problem	☐ Medication Allergy
☐ Kidney Problem	☐ Orthopedic Problem	☐ Surgeries _____

☐ Vision/Hearing Impairment ▶ ☐ *Wears glasses* ☐ *Wears contacts* ☐ Hearing Aid

Life threatening Allergies and treatment (please explain in detail)
Medication Allergy:_____
Food:_____
Insect/Bees: _____
Other pertinent medical condition and current treatment (please explain): _____
_____
_____

Date of last: Physical exam _____ Dental exam _____ Vision exam _____ Hearing exam _____

Must student restrict PE? _____ If yes, please provide documentation from physician.

Pediatrician/M.D. name: _____ M.D. phone number _____

Preferred Hospital/Care Center_____ Emergency Treatment Card on file? (obtained from care center)

MEDICATION:
Students may not carry medication, including over-the-counter medication, on their person at school. However, there are 3 medications that a student can keep in their backpack for emergency purposes only (diabetic supplies, inhalers, and Epi-pens) If your student needs to take medication during school hours or carry emergency supplies an **AUTHORIZATION FOR MEDICATION TAKEN DURING SCHOOL HOURS** form can be obtained from the Health Office. The form must be completed and signed by the student's physician before the medication can be dispensed, and must be renewed yearly.

Medication student takes at school _____

Medication student takes at home _____

COMMUNICABLE DISEASES: Please give date if student has had any of the following:

Chicken Pox _____ German Measles _____ Measles _____

Mumps _____ Tuberculosis _____

Whooping Cough (Pertussis) _____ Required Booster (Tdap) Date: _____

The above information is complete, true and correct. I understand this student health inventory is confidential and will only be shared with designated staff on a "need to know" basis to ensure my child's health and safety at school. I also understand this information will become a part of my child's permanent school health record. If my child requires medication in the original or properly pharmacy-labeled container at school, I will complete an authorization form at the beginning of each school year or as needed throughout the school year. I also agree to alert the school health office personnel if there is any change in my child's health status during the school year.

SIGN HERE

_____ Date: _____
Signature of parent/guardian