NATCHITOCHES PARISH SCHOOLS
STUDENT HEALTH RECORD
TO BE COMPLETED BY PARENT/LEGAL GUARDIAN EACH SCHOOL YEAR

DATE: _____ SCHOOL: _____ GRADE: _____

NAME: LAST: _____ FIRST: _____ MIDDLE: _____ DATE OF BIRTH: _____ SEX: ___M ___F

PARENT/GUARDIAN: LAST: _____ FIRST: _____ MIDDLE: _____

HOME ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

TELEPHONE: MOTHER: HOME: _____ WORK: _____ CELL: _____ OTHER: _____
FATHER: HOME: _____ WORK: _____ CELL: _____ OTHER: _____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____ TELEPHONE: _____

PRIMARY CARE PHYSICIAN/PEDIATRICIAN: _____ OTHER MEDICAL SPECIALISTS/SPECIAL CLINICS: _____

STUDENT HEALTH HISTORY: (PLEASE COMPLETE ALL THAT APPLY)

ASTHMA		DIABETES	SEIZURE DISORDER	ALLERGIES		OTHER HEALTH CONDITIONS	
Medication:	Name	Insulin: Syringe ___ Pen ___ Pump ___	Type of Seizure:	Insects (kind of insect	Type of Reaction		Anemia
Inhaler		Name of Insulin (s)	_____Absence (staring,unresponsive				ADHD
			_____Grand Mal/Convulsive	Nuts: Type:			Cancer
Nebulizer		Oral Medications: _____ Time Given:	_____ Other Describe Seizure: _____	Seafood/Fish Type:			Cerebral Palsy
				Wheat			Cystic Fibrosis
Oral Asthma Medication		When Insulin Given: Morning/Time: _____	Length of Seizure: _____ How Often has Seizure: _____	Gluten			Depression
				Other:			Digestive Disorders
What causes Asthma Symptoms:		Evening/night: _____	Last Seizure: _____	Other			Emotional Psychological
		Other: _____	Medication (s) _____				Rheumatoid Arthritis
		Blood Glucose Monitoring: ____ Times: _____	Times Given:				Hemophilia
How often has Asthma Symptoms:		Check for Ketones: _____		Medication(s) for Allergy			Headaches
___Weekly ___Monthly ___Yearly ___Winter ___Spring ___All Year		Glucagon: ____Yes ____No Carbohydrate Count: _____		Times Given:			High Blood Pressure
							Kidney Disease
							Physical Disability
							Sickle Cell Disease
							Sickle Cell Trait
							Skin Disorder
							Speech Problem
							Other:
							Surgery

Medication taken for Other Health Conditions: _____yes _____no: List any medication(s): _____

Special Procedures Required: __yes __no (Explain) _____ Special Diet: __yes __no (Need Physician Statement) Type: _____

___Vision Conditions: _____Glasses/Contacts ____Other (Explain) _____

___Hearing Conditions: _____Hearing Aid(s) _____Other (Explain) _____

(School Nurse sign if parent /legal guardian indicates medical condition)

_____
School Nurse

IS STUDENT IN COMPLIANCE WITH IMMUNIZATION POLICY? ____yes ___no
(If not sure, please check with Office of Public Health or Physician)

Comments: _____