Eastern Lancaster County School District - Student Health Inventory

(to be completed by parent/guardian)

The information requested on this health profile will become a part of your child's confidential school health record.

Student's Full Name	Birth Date	Grade	Today's Date

Immunizations: Attach a copy of the student's immunization record or a doctor verified immunization record.

INDICATE IF A STUDENT HAS BEEN DIAGNOSED BY A LICENSED HEALTHCARE PROVIDER WITH ANY OF THE FOLLOWING: If your child has a condition that requires medication or treatment at school, contact the School Nurse to obtain the correct required forms.

Health Condition	No	Yes	
ADD/ADHD	☐	☐	Medication taken at home: Medication required at school:
Allergies to Medications	☐	☐	List:
Allergies to Food	☐	☐	List Food(s): _____ Describe the reaction _____ Does your child require Benadryl? ☐ No ☐ Yes EpiPen? ☐ No ☐ Yes
Allergy to Bee Stings	☐	☐	Describe the reaction _____ Does your child require Benadryl? ☐ No ☐ Yes EpiPen? ☐ No ☐ Yes
Allergies (other)	☐	☐	List:
Asthma	☐	☐	Triggers/symptoms _____ Medication taken at home: Medication required at school:
Blood Disorder	☐	☐	Specify: Treatment:
Bone/Muscle Problems	☐	☐	Specify: Activity Restrictions:
Bowel/Digestive/Eating Issues	☐	☐	Specify:
Cancer	☐	☐	Specify: Treatment:
Concussion/Head Trauma	☐	☐	Specify: Date(s):
Congenital abnormality/ Birth defect	☐	☐	
Diabetes	☐	☐	☐Type 1 (Insulin Dependent) ☐Type 2 List medications:
Eye or Vision Problems	☐	☐	Specify: Preferential seating: ☐ No ☐ Yes
Hearing Loss	☐	☐	Specify: Preferential seating: ☐ No ☐ Yes
Heart Condition	☐	☐	Specify:
Kidney/Bladder problem	☐	☐	Specify:
Migraine Headaches (Diagnosed)	☐	☐	Triggers: Treatment:
Mental Health (Emotional, Behavioral, etc.)	☐	☐	Specify: Treatment/Medication:
Seizure Disorder	☐	☐	Type of seizure: List medications:
Other issues / Recent surgery	☐	☐	Specify: Date(s):

DISPENSING OF MEDICATIONS: **SECONDARY ONLY**	The school nurse of Eastern Lancaster County School District has standing orders signed by the school physician that allow the administration of certain medications to students with parental consent. These medications include: Tylenol, antacid chewable tablets, throat lozenges and cough syrup. If your child is not allergic to the medications, may the school nurse or designated personnel administer these medications to your child if illness/symptoms warrant?	☐ Yes ☐ No	Initials

- Over-

Tuberculosis Exposure Assessment Has your child had any contact with an adult with infectious tuberculosis?	☐ No	☐ Yes
Are you or your child foreign born or does anyone in your family travel outside the U.S.? Regions that are especially at high risk are Latin America, Mexico, Philippines, Caribbean Islands, Asia, and Africa.	☐ No	☐ Yes
Does your child have any of the following medical risk factors: Hodgkin's disease, lymphoma, diabetes, chronic renal failure, or malnutrition?	☐ No	☐ Yes
Does your child have an immunosuppressive condition such as HIV infection or has your child been exposed to individuals with HIV infection?	☐ No	☐ Yes
Is your child frequently exposed to adults in any of the following groups: Residents of nursing homes, migrant farm workers, IV drug users, homeless individuals, and incarcerated adolescents or adults?	☐ No	☐ Yes

Medical examinations are required on original entry (Kindergarten or Grade 1), Grades 6 and 11, and any other grade if moving in from out of state. You may choose to have these exams done by your family physician or it will be done at school by the school physician.

☐ School Physician
OR
☐ Name of Family Physician _____ Phone Number: _____

Date of most Recent Physical exam: _____ Parent Signature: _____

Dental examinations are required on original entry (Kindergarten or Grade 1), Grades 3 and 7, and any other grade if moving in from out of state. You may choose to have these exams done by your family dentist or it will be done at school by the school dentist.

☐ School Dentist
OR
☐ Name of Family Dentist: _____ Phone Number: _____

Date of most Recent Dental exam: _____ Parent Signature: _____

Preferred Hospital – in case of emergency, your child will be taken to the nearest hospital or physician
Hospital Name _____

- In the event I cannot be reached in an emergency, I hereby give my permission to the attending physician and/or hospital staff to give emergency treatment to my child. ☐ Yes ☐ No Initials _____
- Please contact the school nurse if there any changes in your child's health status.
- All information may be shared in a confidential manner with appropriate school personnel as needed in order to provide for your child's educational, health and safety needs.

_____ _____ _____
PARENT/GUARDIAN SIGNATURE *PRINTED NAME* *DATE*