



Universal Academy Charter School 2018-19 Health Information Form

PLEASE USE INK, not pencil

Student's Name _____
Last, First Middle
Birthdate
Age
Grade

1. Has student had any of the following problems or injuries? (Examples in parenthesis)

Describe problem for each Yes on the lines at the bottom of the page ↓.

Surgery --Date of any surgeries:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Head Injury or Concussion	<input type="checkbox"/> Yes <input type="checkbox"/> No
Ear infections (<i>often has them, ear tubes, etc</i>)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Nose problems (<i>sinus infections, nose bleeds</i>)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Eye problems (<i>blurry vision, wears glasses, lazy eye</i>)	<input type="checkbox"/> Yes <input type="checkbox"/> No
----Should wear glasses or contacts to see <input type="checkbox"/> far away <input type="checkbox"/> read	
Hearing problems (<i>has trouble sometimes, wears hearing aid</i>)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mouth or throat problems (<i>Strep throat, swallowing problems</i>)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Constipation (<i>problems having a bowel movement (BM)</i>)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Problems peeing (<i>bed wetting, pain when peeing</i>)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Back problems (<i>crooked back, back pain</i>)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Muscle and bone problems (<i>weak muscles, pain in joints</i>)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Skin problems (<i>acne, flaking skin, rashes, hives</i>)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Seizures (<i>shaking fits or convulsions</i>)	<input type="checkbox"/> Yes <input type="checkbox"/> No
ADD/ADHD (<i>problems paying attention, sitting still</i>)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Breathing problems (<i>cough, asthma</i>)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart problems (<i>fast or irregular heartbeat, murmur, birth defect</i>)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Feelings or emotions (<i>depression, anxiety, fears</i>)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other:	<input type="checkbox"/> Yes <input type="checkbox"/> No

Did you mark yes for any problems above? Tell us more here: _____

2. Does student have any allergic reactions (bad effects) from any of the following? (Check all that apply.)

- Outside or Indoor allergies, (*for example: hay fever, grass, pollen, cats ...*) Please list below ↓
- Food Allergies (*for example: peanuts, milk, wheat ...*) Please list below ↓
- Insect or Animal Allergies (*for example: bees, wasps, cats...*) Please list below ↓
- Medicine or shots (*immunization*). Please list below ↓
- No, my child has no allergies that I know of.

Student is allergic to:	What happens when he/she has a reaction?

Student is allergic to:	What happens when he/she has a reaction?

Does student have an Epi-Pen? Yes No If YES, please bring one to school

3. Has student ever been a patient in a hospital (other than a few days after birth)?

- No
 Yes (If yes, explain why and when below.)

<u>Student was in the hospital because:</u>	<u>Age</u>
<u>Example:</u> Bike accident-concussion	5 years old

4. Does student take any prescription medicines? Or have an inhaler or breathing treatments?

- No.
 Yes - Please list below

Albuterol inhaler	Before exercise	asthma

5. Does student take over-the-counter medicine?

- Vitamins
 Herbal medicine (please list) _____
 Other medicines like Tylenol, Advil or something else? (Please list) _____
 None, my child does not take any over-the-counter medicines regularly.

By signing below I give permission for this school to contact student's medical clinic IF NEEDED to obtain medical information regarding this student's health including medications.

Student's medical clinic is: _____ or Student needs a clinic _____

Signature of person completing this form

Relationship to student

Date

* Please note: Confidential information about your student's health may be shared only with other school staff that need to know to protect your child's safety. They are told to keep this health information private and not to share with anyone else. If there is health information you would like not to be shared, please contact the school nurse.