School District of Manawa

Student Health Services
District Nurse Olivia Koehn RN, BSN|(920) 596-5841
Health Aide MES Kris Thompson|(920) 596-5735
Health Aide LWJSHS Sandy Dunnihoo|(920) 596-5845
Elementary Fax (920) 596-5339 | Jr./Sr. High Fax (920) 596-2655

New Student Health Information Form

Student Name _____ Date of Birth _____

School _____ Teacher _____

Student ID # _____ Grade _____ Gender M F

Parent/Guardian Name _____

Parent/Guardian Name _____

Please keep all parent/guardian and emergency contact information current with school office staff. In the event of an emergency we will attempt to contact parents/guardians followed by emergency contacts in the order on file.

Health History (circle any conditions your child has a history of and write in the age of your child at the time of the illness. Please also write CURRENT if a diagnosis is still currently a health issue for the student):

Asthma	Diabetes	Seizure Disorder
Allergies-food/nonfood items/insect bites/seasonal		Obesity/overweight/underweight
Skin Condition/Rash	Lupus	Anxiety/Depression
Heart failure/condition	Kidney Disease	Diet Restriction
Phenylketonuria (PKU)	Bowel/bladder control issues	Anemia
Chicken Pox (Varicella)	Diphtheria	Strep Throat
Measles	Polio	Tonsillitis
German Measles (Rubella)	Hepatitis	Meningitis
Mumps	Frequent Stomach Aches	Hernia
Scarlet Fever	Pneumonia	Mononucleosis
Rheumatic Fever	Cancer	Frequent headaches
Whooping Cough (Pertussis)	Tuberculosis	Frequent ear infection
Fractures (Broken Bones)	Sexually Transmitted Infection	HIV/AIDs
Orthopedic (bone and muscle) issues Arthritis		

Please write in any other missed condition in your child's health history or current health issues not included in the above list:

_____

Please write in any notes to clarify (for example what type of bowel/bladder problems or what type of congenital heart disease) or any other information of which the nursing services should be aware.

_____

Turn Over

Please list all medications your child is taking:

_____

Will skilled nursing services (tracheostomy, catheterization, etc.) be needed? If yes. please explain.

_____

Please list all surgeries/procedures your child has had:

_____

Will your child have any limitations to participation in classroom learning? If yes, please explain.

_____

Will your child have any limitations to participation in physical education/sports/ extracurricular activities? If yes, please explain.

_____

Does your child have a primary care provider? Y or N How often does your child see this provider? _____

Name of primary care provider: _____

Does your child see a dentist regularly? Y or N

Name of dentist: _____

Does your child wear glasses? Y or N **Does your child wear contact lenses? Y or N**

Does your child see an eye specialist regularly? Y or N

Name of eye specialist: _____

***Based on information gathered from this form additional forms may need to be filled out and will be dispersed to parent/guardian of student as necessary.**

Parent consent for management of health conditions while at school or other school related activities

I, the parent/guardian of the above-named student, grant permission for designated school staff to care for my child's health condition(s) at school as needed. Furthermore, I agree to:

1. Provide the necessary supplies and equipment.
2. Notify the school staff or school district nurse of any changes in the student's health status.
3. Notify the school staff and complete new consent for changes in orders from the student's health care provider.
4. Authorize the school nurse to communicate with my child's primary care physician or specialist regarding my child's health condition as needed.
5. School staff interacting directly with my child may be informed about this health care plan.
6. Submit new forms annually if the health condition still exists or inform the school that the condition no longer exists.
7. Hold without liability the School district of Manawa, its Board of Education, administration, and all employees and agents who are acting within the scope of their duties in all claims arising from the administration of this medication and treatment of this health condition, to policy at school.

Parent/Guardian Signature_____ Date_____

Student Signature (if student is currently or will turn 18 during school year) _____ Date_____