SEYMOUR R-II SCHOOLS STUDENT HEALTH INVENTORY
SCHOOL YEAR: 2023-2024

Please Print **Grade/Teacher _____ / _______________________________**
School: *(check one)* □ **High School** □ **Middle School** □ **Elementary** □ **Preschool**
Student's Name ______________________________ Birth Date _______________ □Male □Female
Parent/Guardian: ______________________________ Phone: ________________ Employer: ____________________
Parent/Guardian: ______________________________ Phone: ________________ Employer: ____________________
Emergency Contact Other than Parent: ______________________________ Phone: ___________________________

Medical Information:
Insurance: □ YES □ NO

Where do you take your child to seek medical care?
□ No Regular Source □ Emergency Room □ Physician/Clinic/Primary Care Provider
Hospital Preference: ____

IN CASE OF AN EMERGENCY AND YOU CANNOT BE REACHED, YOUR CHILD WILL BE TRANSPORTED TO THE HOSPITAL AT YOUR EXPENSE.

Does your child have a diagnosis confirmed by a doctor of:

Asthma /Non-medicated □Yes □No Trigger: ____________________ Treatment: ____________________
Asthma/Medicated □Yes □No Trigger: ____________________ Treatment: ____________________
Severe Insect Allergy □Yes □No Specify Insect/Reaction: _________________ Treatment: ____________
Food Allergies □Yes □No Specify Food/Reaction: _________________ Treatment: ____________
Hay Fever □Yes □No Treatment: ____
Other Allergies □Yes □No Specify: ____
Ear Tubes □Yes □No Date: ____
Type 1 Diabetes □Yes □No Medication: ____
Type 2 Diabetes □Yes □No Medication: ____
Migraines □Yes □No Treatment: ____
Heart Condition □Yes □No Specify: ____
Kidney/Bladder Disorder □Yes □No Treatment: ____
Nosebleeds (frequent) □Yes □No Treatment: ____
Hearing Problems □Yes □No Hearing Aids Required: □Yes □No
Vision Problems □Yes □No Glasses: □Yes □No Contacts: □Yes □No Last eye exam: __________
Attention Deficit Disorder □Yes □No Medication: ____
Attention Deficit Hyperactivity □Yes □No Medication: ____
Autism □Yes □No Specify: ____
Behavior Disorder □Yes □No Specify: _________________________ Treatment: _________________
Mental/Emotional Disorder □Yes □No Specify: _________________________ Treatment: _________________
Seizures □Yes □No Specify: ____
Date of last seizure: ________________ Medication ______________________________
Other diagnoses not listed □Yes □No Specify: ____

Does your child have a special health care need: □ **Yes** □**No** Specify: ______________________________
Does your child have a condition that might limit PE participation: □ **Yes** □**No** Specify: ____________________
Does the special health care need require special equipment or arrangements? □ **Yes** □ **No**
Additional Comments: ____

PLEASE DON'T FORGET THE BACK!!!

Does your child take medication: □ **Yes** □ **No**

Name of Medication ______________ How often: ______________ For: ______________
Name of Medication ______________ How often: ______________ For: ______________
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Name of Medication ______________ How often: ______________ For: ______________

Will your child need to take medication while at school? □ **Yes** □ **No**

Name of Medication ______________ Dosage: ______________ Time: ______________
Name of Medication ______________ Dosage: ______________ Time: ______________
Name of Medication ______________ Dosage: ______________ Time: ______________

If your child requires medication to be given during school hours, please contact the nurse for required paperwork that must be completed **BEFORE** any medication can be given at school. Per school policy, students should not carry **ANY** medication during school hours unless approved by the school nurse.

Over-the-Counter Medications: Standing orders by a local physician allow the school nurses to provide the following medications to students according to nursing judgment. A doctor's order is required for medication administration outside of the standing orders. Standing orders may be updated as needed throughout the school year. Please mark through any of the following medications you do **NOT** wish your child to have.

Ibuprofen: For minor aches and pains, headache, backache, earache, toothache, premenstrual/menstrual cramps. Not for fever. May not exceed more than 1 dose daily or 2 consecutive daily doses without further evaluation and written order from family physician.
Acetaminophen: For minor aches and pains, headache, backache, earache, toothache, premenstrual/ menstrual cramps. Not for fever. May not exceed more than 1 dose daily or 2 consecutive daily doses without further evaluation and written order from family physician.
Anbesol/Orajel: for the temporary relief of pain associated with toothache, sore gums, canker sores, braces, minor dental procedures, and dentures.
Antacid: to relieve heartburn, sour stomach, acid indigestion, or upset stomach associated with these symptoms.
Antibiotic Ointment: to prevent infection in minor cuts, scrapes, and burns.
Benadryl/Diphenhydramine HCL: Hives and/or allergic reactions not severe enough for epinephrine with parent approval.
Caladryl/Calamine: for the temporary relief of pain and itching associated with minor skin irritations and rashes due to point ivy, poison oak, or poison sumac.
Contact Solution/Contact Eye Drops: for use when requested for contacts.
Cough drop/Throat Lozenges: 1 every hour as needed for cough or sore throat, not to exceed 3 daily.
Hydrocortisone 1% cream: for the temporary relief of itching associated with minor skin irritations and rashes.
Icy Hot: to help with pain from arthritis, backache, muscle strains, sprains, bruises, cramps
Salt Water Gargle: 1/4-1/2 teaspoon salt dissolved in 8 ounces of water for sore or scratchy throat.
Sterile Eye wash: to help flush loose foreign material or chemicals from the eyes. To help relieve eye irritation, burning, itching, and stinging by removing air pollutant (smog or pollen) or chlorinated water.
Vaseline/Petroleum Jelly: for the temporary relief of chapped lips or skin.

Sharing of Medical Information: To provide the best care possible to your child while at school, it may be necessary to communicate some aspects of your student's health information to other school staff. It may also be necessary to communicate with your child's medical provider(s).

Parent/Guardian's Name: ______________ **Phone:** ______________

Parent/Guardian's Signature: ______________ **Date:** ______________

Parent/Guardian's Email Address: ______________