STUDENT MEDICAL HISTORY INFORMATION

Student Name: _____ Birthdate: _____ School Year _____Grade:_____

Street Address: _____City:_____County:_____

State & Zip Code _____Home Phone # _____Cell Phone #_____

V _____ Video Relay:_____ E-mail address_____

Please indicate which contact & # you prefer us to try 1st, 2nd, etc

Parent 1: Name:_____Work Place:_____Work Phone:_____

Pager or Cell #_____

Parent 2: Name_____Work Place:_____Work Phone:_____

Pager or Cell #_____

EMERGENCY REFERENCES (Please list three)

Name	Relationship to Student	Area Code & Phone # (TTY?)

HEALTH INSURANCE INFORMATION

Insurance Company Name:_____

Subscriber:_____

Policy# & Group:_____

Medicaid# _____

Parent Permission to Administer O.T.C. Medication at School

I, hereby give my permission for my child, _____, to receive any of the over the counter medications (O.T.C.) checked below by the health services staff or designee while attending the Arkansas School for the Deaf. I understand that these medications will be given per health services standing orders as prescribed by the school physician. I understand that the generic equivalent may be used. **Cross out the items the student should not be given.**

MEDICATION	REASON TO GIVE
Acetaminophen (Tylenol)	Fever, headaches, pain
Ibuprofen (Advil, Motrin)	Fever, headaches, pain
Antacid	Upset stomach
Antibiotic ointment	Minor cuts/abrasions
Cough drops	Minor sore throat
Cough syrup	Cough
Cortisone cream	Insect bites, skin irritations
Antihistamines	Stuffy nose, allergic reactions
Ear wax solutions (Debrox)	Ear wax removal
Antifungal cream	Body/foot fungal infections
Milk of Magnesia	Constipation
Eye drops/Eye wash	Eye irritations
Sunscreen	Outdoor Sun Exposure

Signature of Parent/Guardian _____Date _____

Health Questionnaire: check conditions that apply to your child – describe under Comments.

_____ ADD/ADHD

_____ Anxiety/Panic attack

_____ Asthma

_____ Bee Sting Allergy

_____ Behavior Problem

_____ Bowel Problem

_____ Cardiac Problem

_____ Cerebral Palsy

_____ Diabetes

_____Epi-Pen

_____ Emotional Concerns

_____ Food Allergy

_____ Headaches

_____ Kidney/Urinary Problem

_____ Respiratory/lung condition

_____Depression

_____Stomach/liver/gallbladder

_____Vision Problems

_____Seizures

_____Spina Bifida

_____Muscle disorder

_____Neurological Problems

_____Orthopedic Problems

_____Scoliosis

MENTAL, EMOTIONAL, AND SOCIAL HEALTH ISSUES

CHECK "YES" OR "NO" FOR EACH STATEMENT

HAS YOUR CHILD EXPERIENCED ANY OF THESE:

1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)_____Yes_____No
2. Ever been treated for emotional or behavioral difficulties/problems? _____Yes_____No
3. Ever been treated for eating disorders or eating problems? _____Yes_____No
4. During the past 12 months been hospitalized for mental/emotional/mental health concerns? _____Yes_____No
5. During the past 12 months, has your child seen a professional who has addressed mental/emotional/mental health concerns?_____Yes_____No
6. Has there been a significant life event that continues to affect your child's life? _____Yes_____No
   (History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster or anything else)

PLEASE EXPLAIN ANY OF "YES" ANSWERS IN THE SPACE BLEOW. NOTE THE NUMBER OF THE QUESTIONS.

********ALLERGIES (FOODS OR DRUG) *********LIST BELOW*************

List of Allergies to Foods or Drugs:

What is the cause of your child's loss of hearing?
_____

Does your child wear hearing aids? Yes _____ No _____

Does your child have cochlear implants? Yes _____ No_____ If yes, date of implant: _____

List any other operations, injuries, or hospitalizations your child has had: Give dates:

_____

_____

_____

_____

Is your child on any medication every day or as needed? Yes ____ No ____

List: _____

Does your child have any physical restrictions? Yes ____ No ____

List: _____

Does your child require mobility assistance? Yes ____ No ____

If so, what type _____

Does your child wear glasses? Yes ____ No ____ Contact lenses? Yes ____ No ____

PHYSICIAN INFORMATION	
Primary Care Physician:	Phone:
Dentist:	Phone:

PLEASE NOTE: Health information will be shared with all employees having a need to know, unless Health Services is notified otherwise. Parents/Guardians are responsible for notifying health services of any changes in the child's health.

Parent/Guardian Signature: _____Date: _____

Rev: 06/18

ASD DOES NOT PROVIDE 24 HOUR NURSING CARE. A NURSE IS AVAILABLE BY TEXT/PHONE AT ALL TIMES