IUSD HEALTH SERVICES (949) 936-7520

HEALTH CONDITION INFORMATION

School: _____ Date: _____

Teacher/Counselor: _____ Grade: _____

Student's Last Name: _____ Student's First Name: _____ Date of Birth: _____ Gender: ☐ Male ☐ Female

Physician's Name: _____ Physician's Phone Number: _____ ☐ non-binary

☐ Yes ☐ No Does this student have health insurance?

☐ Yes ☐ No If no, would you be interested in receiving information about possible health insurance options?

☐ Yes ☐ No **Has this student been diagnosed with or treated for *ANY* medical conditions?**
If yes, please list and describe or explain the medical condition(s): _____

☐ Yes ☐ No **Could any of these conditions affect this student's ability to participate in routine school activities or programs, either in the classroom or during physical activity:**
Please list and explain any medical restrictions, considerations, or special needs: _____

☐ Yes ☐ No **Does this student require any special health procedures during the regular school day?**
If yes, please list the procedures and any equipment that will be needed: _____

☐ Yes ☐ No **Does this student take any prescription or non-prescription medication, either regularly or occasionally, at home or at school?**
If yes, please complete the following:

Medication: _____ Dose/time/frequency given: _____ Reason for medication: _____ Needed: ☐ at home ☐ at school ☐ both

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All prescription or non-prescription medication needed at school requires a written physician order and parental consent. Medication forms are available on line at www.iusd.org.

☐ Yes ☐ No Does this student have any difficulty with vision?

☐ Yes ☐ No Does this student wear glasses or contact lenses?

☐ Yes ☐ No Does this student have a hearing loss?

☐ Yes ☐ No Does this student wear a hearing aid? If yes: ☐ Right ear ☐ Left ear ☐ Both ears

Please remember that any student's education can be affected by medical, developmental, or emotional conditions and it is a parent/guardian responsibility to immediately notify the school nurse of any changes in the student's health status. This information may be shared with teachers and other appropriate school personnel who care for your child. By signing below, you are affirming that the above statements are true to the best of your knowledge and giving permission for school personnel to contact the physician if needed.

Parent/Guardian /Caregiver/POA Signature: _____ Relationship to student: _____ Best way to reach me: Phone: _____ Email: _____

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For School Use Only