DES MOINES PUBLIC SCHOOL ANNUAL HEALTH REVIEW (MIDDLE AND HIGH SCHOOL) SCHOOL YEAR _____

Student Name: _____Date: _____ Birth Date: _____ Grade: _____

Health Review:

Breathing Problems	**Heart Problems**	**Neurologic Problems**	**Eating Problems**	**Gland Problems**	**Orthopedic**
___ Asthma	___ Heart Murmur	___ Frequent Headaches	___ Stomach Problems/Ulcer	___ Diabetes	___ Broken Bones
___ Reactive Airway	___ Heart Surgery	___ Dizziness ___Fainting ___Seizure	___ Bowel Problems	___ Thyroid	___ Orthopedic Braces
___ Other Problem	___ Other Problem	___ ADHD/ADD	___ Special Diet at School	___ Other Problem	___ Other Problem

Dr. Ordered Special Needs: ___Glasses/ Contacts ___Hearing Aids ___Seat Close to Instruction ___Liberal Bathroom Privileges ___Physical Education Limits

List Your Child's Allergies: Food _____ Medicine_____

Environmental _____

List any illnesses, operations, or accidents your child has had in the past year: _____

List any emotional, social, or other conditions that might affect your child's school performance: _____

List other health concerns you would like the nurse to know about: _____

Current Medications _____ Medications Given at School _____

International Travel: My child has been outside the United States during the past year. ___Yes ___No Name of Country:_____

PARENT AUTHORIZATIONS: Please read and give consent by signing each statement

Over The Counter Medications In Middle and High Schools:
I give permission to the school nurse to give my child an age appropriate dose of Acetaminophen (Tylenol) or Ibuprofen (Advil) when needed-Up to 5 total doses/ year without a Dr. order. **Cough Drops and Chapstick: Will be allowed in class - Individual teachers may refuse the privilege if misused.

******PARENT SIGNATURE: _____ Date :_____**

Health Information: I give permission to the school nurse to share educationally relevant health and emergency information (to include medical diagnosis) with school staff on a need to know basis.

******PARENT SIGNATURE: _____ Date:_____**

Health Insurance Information: _____ Private _____ Medicaid _____ hawk-i _____ No Insurance
____ I give permission for the nurse to contact me about health insurance options or refer to an appropriate community agency for health insurance assistance

Emergency Information: Doctor Name: _____ Hospital of Preference: _____

Parent Numbers: 1. _____ 2. _____ 3. _____

E-Mail _____

NURSES SIGNATURE:_____ **INITIALS:** _____ **NURSES SIGNATURE:**_____ **INITIALS:** _____

	DATE	TIME IN	TIME OUT	TOTAL	CODE	PROGRESS NOTES - COMMENTS	CONTACT	DISPOSITION	INITIAL

Code 1 – Screening; Code 2 – Nursing; Code 3 – Assessment; Code 4 – Medication; Code 5 – Contracted Nurse; Code 6 – Medical Supplies; Code 7 – Non Licensed Care

Student Name: _____ **School:**_____ **Year:**_____