STUDENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade:\_\_\_\_\_ School:\_\_\_\_\_\_\_\_\_\_\_

| HEALTH CONCERNS | YES | NO | MEDICATION | MONITORING IN SCHOOL? | COMMENTS |
| --- | --- | --- | --- | --- | --- |
| ASTHMA |  |  |  |  |  |
| ALLERGIES |  |  |  |  |  |
| DIABETES |  |  |  |  |  |
| SEIZURES |  |  |  |  |  |
| MIGRAINES |  |  |  |  |  |
| HEAD INJURY |  |  |  |  |  |
| HEART/BLOOD |  |  |  |  |  |
| MUSCLES/JOINT/BONE |  |  |  |  |  |
| SKIN CONDITIONS |  |  |  |  |  |
| STOMACH/BOWELS |  |  |  |  |  |
| IMMUNE PROBLEMS |  |  |  |  |  |
| NUTRITIONAL/DIET |  |  |  |  |  |
| DEVELOPMENTAL |  |  |  |  |  |
| EMOTIONAL/BEHAVIORAL |  |  |  |  |  |
| BLADDER/KIDNEY |  |  |  |  |  |
| OTHER HEALTH CONCERN |  |  |  |  |  |

• Routine or daily medications, treatments or therapies (not listed above):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

• Special medical equipment required in school? (eg. oxygen, wheelchair) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

• ILLNESSES, HOSPITALIZATIONS, ACCIDENTS/ INJURIES and dates: (use other side if necessary)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child wear glasses or contacts? Y / N Just for reading or all the time?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child wear hearing aids or have hearing concerns? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health Care Provider(s) & Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PARENT/GUARDIAN SIGNATURE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Nombre de estudiante: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fecha de nacimiento:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grado:\_\_\_\_\_\_

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| SALUD CONCIERNE | SI | NO | MEDICINA | VIGILANCIA EN ESCUELA? | COMENTARIOS |
| ASMA |  |  |  |  |  |
| ALERGIAS |  |  |  |  |  |
| DIABETES |  |  |  |  |  |
| TOMAS |  |  |  |  |  |
| MIGRAÑAS |  |  |  |  |  |
| HERIDA EN LA CABEZA |  |  |  |  |  |
| CORAZON/SANGRE |  |  |  |  |  |
| MUSCULOS/ HUESOS |  |  |  |  |  |
| CONDICIONES DE EL PIEL |  |  |  |  |  |
| ESTOMAGO/INTESTINOS |  |  |  |  |  |
| PROBLEMAS INMUNES |  |  |  |  |  |
| NUTRICIÓN/DIETA |  |  |  |  |  |
| PREOCUPACIONES DE DESARROLLO |  |  |  |  |  |
| EMOTIONAL/BEHAVIORAL |  |  |  |  |  |
| VEJIGA / RIÑON |  |  |  |  |  |
| OTRAS PREOCUPACIONES DE SALUD |  |  |  |  |  |

• Medicamentos, tratamientos o terapias de rutina o diarias (no mencionados anteriormente):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

• ¿Se requiere equipo médico especial en la escuela? (oxígeno, silla de ruedas)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

• ENFERMEDADES, HOSPITALIZACIONES, ACCIDENTES / LESIONES y fechas: (use el otro lado si es necesario)\_\_\_\_\_\_\_\_\_

¿Su hijo/a usa anteojos o lentes de contacto? S / N ¿Solo por leer o todo el tiempo?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

¿Su hijo usa audífonos o tiene problemas de audición?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Proveedor de atención médica y número de teléfono: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PARENT/GUARDIAN SIGNATURE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_