SCHOOL DISTRICT OF NIAGARA STUDENT HEALTH INFORMATION 2024 – 2025

The following health information is confidential, but pertinent health information may be shared with school staff on a need-to-know basis to provide the best care for your child. If you do not want health information shared, you must provide a written request.

STUDENT NAME: ____ GRADE: ______________

Please see the school nurse for any items marked "yes" in the following questions 1-5.

1. **ALLERGIES**

_______**YES** **FOOD: What type of food?** ____

Medication needed to treat reaction at school? **Yes**__________**(CALL/SEE NURSE) No**___________

Type of Medication: EPI-PEN ________ Antihistamine ______________ Other ______________

_______**YES** **Bee/Wasp Sting:**

Medication needed to treat reaction at school? **Yes**__________**(CALL/SEE NURSE) No**___________

Type of Medication: EPI-PEN ________ Antihistamine ______________ Other ______________

_______**YES** **Other Allergies**: Please List: ____

Medication needed at school for symptoms? **Yes**__________**(CALL/SEE NURSE) No**___________

2. **ASTHMA**

_______**YES** Asthma triggers: ____

Medication needed to treat symptoms at school? **Yes**__________**(CALL/SEE NURSE) No**___________

Inhaler ______________ Nebulizer _________________ Other ___________________________

3. **DIABETES**

_______**YES** **Call/See Nurse**

Medication taken at school: Insulin ______________ Oral ___________________________

4. **SEIZURE DISORDER**

_______**YES** **Call/See Nurse**

Medication taken at school: ____

5. **Does your child have any other health conditions/concerns the school should be aware of**?

_______**YES** ________ **NO** **If yes, please list medical condition or health/other concerns:**

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Please list routine daily medications your child will need to take during the school day:

Medication ____ Time _____________________(Contact the school nurse)

Does your child wear: Glasses? _________________ Contacts? ________________________

I give my child permission to participate in hearing/vision screening: Yes__________ No__________

Any other information you feel would be helpful to school personnel in caring for your child at school:

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If emergency care is required, and no one can be reached, may the school authorities use their judgment in caring for your child? Yes__________ No__________ If no, indicate plan to follow: ______________________________

____

Your signature gives the school personnel and hospital permission to provide first aid/other medical/emergency care, and is intended for use throughout this school year. Please notify the school personnel of any changes by calling 715-251-4541.

____ ________________________

Parent/Guardian Signature **Date**