Diocese of Des Moines EVERY PUPIL - EVERY FALL FORM School Year: _____

STUDENT NAME: _____ DATE: _____ BIRTH DATE: _____ GRADE: Please Choose

COUNTRY OF BIRTH: _____ TUBURCULOSIS CERTIFICATE PROVIDED (if not born in the U.S.): Y / N

Health Review

Breathing problems	**Heart problems**	**Neurologic problems**	**Eating problems**	**Gland problems**
☐ Asthma	☐ Heart surgery	☐ Frequent headaches	☐ Stomach problems	☐ Diabetes
☐ Reactive airway	☐ Heart murmur	☐ ADHD/ADD	☐ Bowel problems	☐ Kidney problems
☐ Other problems	☐ Other problems	☐ Seizure disorder	☐ Special diet at school	☐ Thyroid problems

Doctor Ordered Special Need: ☐ Contacts/Glasses ☐ Hearing aids ☐ Seat close to instruction ☐ PE limitations

List Your Child's Allergies: **Food**_____ **Medicine**_____

Environmental_____ **Insect**_____ **Other**_____

List any illnesses, operations or accidents your child has had this 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/teacher to know about_____

Current Medications: _____ Medication to be given at school: _____

Emergency Information: Doctor Name: _____ Phone: _____
Hospital preference: _____

Parent information: Mother: _____ Home: _____ Work: _____
Family E-mail_____ Cell: _____
Father: _____ Home: _____ Work: _____
Cell: _____

Is your child covered by insurance? ○ Yes/No ○ Carrier Name: _____

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: _____