Oak Grove Lutheran School Student HEALTH FORM

Name_____ School Year_____

Grade_____ DOB_____ Sex_____

Student's physician/clinic_____ Phone_____

Student's dentist_____ Phone_____

Does student have medical insurance? YES_____ NO_____

HEALTH HISTORY

[**Y**=currently under treatment **N**=no history **R**=problem in the past but currently resolved]

ADD/ADHD	Y	N	R	Allergies (if yes, see below)	Y	N	R
Asthma	Y	N	R	Heart Condition	Y	N	R
Bone/Joint Problems	Y	N	R	Seizure Disorder	Y	N	R
Diabetes	Y	N	R	Head Injury	Y	N	R
Chronic Ear Infections	Y	N	R	Glasses/Contacs	Y	N	R
Emotional/Behavioral	Y	N	R	Weight Concerns	Y	N	R
Hearing Loss/Issue	Y	N	R	Nosebleed (freq or severe)	Y	N	R
Chronic Headache/Migraine	Y	N	R	Skin Problems (chronic or severe)	Y	N	R

Other concerns which may affect student?_____

ALLERGIES Please list and describe any allergies below. Indicate **mild, moderate,** or **severe:**

Bee/Wasp Stings
Medicines/Drugs
Food/Plants/other
Pollen/Dust/Hay Fever
Recommended treatment student currently receives, or has received in the past: *antihistamines:* *inhalers:* *EpiPen:* *other:*

INJURIES & ILLNESSES Please list any severe injuries or illnesses in the student's history.

Injury/Illness	Age of Child	Hospitalized?

Please complete emergency contact information on reverse.

MEDICATIONS

What medications are given daily? Reason?_____

_____

What medications are given frequently, but not daily? Reason?_____

_____

Will your student need to receive medications during the school day?_____

NOTE: If medication is needed at school a **Medication Administration Form** must be signed by you physician and given to the school nurse. This form may be found at the school office, on the Oak Grove website and at most clinics.

I authorize Oak Grove nurse/school to dispense to my student: **Indicate with Yes or No**

1) Tylenol _____ 2) Ibuprofen _____ 3) Antacid _____

EMERGENCY PHONE NUMBERS and PERSON TO BE CONTACTED WHEN PARENTS/GUARDIAN CANNOT BE REACHED

Mother's Name	Home #	Work #	Cell #
Father's Name	Home #	Work #	Cell #
Other Contact/Relationship	Home #	Work #	Cell #

Please read the following provisions and sign where provided:

☐☐→*In consideration of this authorization made by my request, the school and individual dispensing medication, prescription or non-presciption, are not liable for any injury or damages caused by medication.

☐☐→*The information on this form is true to the best of by knowledge. I hereby give permission in an emergency situation, when I cannot be contacted, to take my child to the closest medical facility and its medical staff has my authority to provide treatment that a physician deems necessary for the well-being of my child.

☐☐→*This form will be utilized for overnight trips, choir tours, mission trips, etc.

→*Information on this form may be shared with appropriate personnel for health and educational purposes.

Parent/Guardian Signature_____ Date_____

Date & Medication &/or Treatment (school use only)

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