



\*\*\*Please fill out a form for each student.

Student: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
LAST FIRST DATE OF BIRTH GRADE

Parent/Guardian:

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
NAME RELATIONSHIP CELL HOME WORK  
\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
NAME RELATIONSHIP CELL HOME WORK

**HEALTH HISTORY:**

NO HEALTH CONCERNS

ADHD/ADD Diagnosed by: Provider Name/Clinic - \_\_\_\_\_  
Medication (name/dose/time) \_\_\_\_\_

Allergies: \_\_\_ Food \_\_\_ Medications \_\_\_ Bee Stings \_\_\_ Seasonal \_\_\_ Other: \_\_\_\_\_  
Describe: \_\_\_\_\_

Life Threatening: \_\_\_ Yes \_\_\_ No Epi Pen: \_\_\_ Yes \_\_\_ No  
Medication: \_\_\_\_\_ Medication/Epi Pen at School: \_\_\_\_\_  
(please fill out emergency action plan which can be found on the MACCRAY Schools website under departments, then health services have it signed by MD annually)

Asthma or other breathing problems: \_\_\_\_\_  
1. Has the student ever been diagnosed by a medical provider as having asthma? Y N  
2. Does the student take medication for asthma? (If yes, list on back of form) Y N  
3. Has the student had an episode of wheezing in the past 12 months? Y N  
4. In the past 12 months, have you heard the student wheeze or cough after physical activity? Y N  
5. Other breathing problems? Describe: \_\_\_\_\_  
(please fill out asthma action plan which can be found on the MACCRAY Schools website under departments, then health services and have it signed by MD annually)

Bladder/Bowel: ie. constipation, accidents (describe): \_\_\_\_\_  
 Diabetes: \_\_\_ Type 1 \_\_\_ Type 2 Managed by: \_\_\_ Diet Only \_\_\_ Oral Meds \_\_\_ Insulin Pump  
\_\_\_ Insulin Injections \_\_\_ CGM

Additional Information:  
(please fill out diabetic emergency action plan with your physician annually)

Seizures: Type (describe): \_\_\_\_\_ Date of Last Seizure: \_\_\_\_\_  
(please fill out seizure action plan which can be found on the MACCRAY Schools website under departments, then health services and have signed by MD annually)

**\*\*\*PLEASE MAKE SURE TO FILL OUT BOTH SIDES OF THIS FORM!\*\*\***

**Social/Emotional/Behavioral/Mental:** Diagnosis:

Diagnosed by: Provider/Clinic/Date - \_\_\_\_\_

Anxiety \_\_\_ Depression \_\_\_ Social Phobia \_\_\_ Panic Attacks \_\_\_ Other \_\_\_\_\_

Medication (name/dose/time) \_\_\_\_\_

Outpatient Therapy: Name of Therapist \_\_\_\_\_ Therapist Phone: \_\_\_\_\_

**Recent Surgeries or Hospitalizations:**

**Activity Restrictions:**

**Please explain any other health concerns or conditions:** \_\_\_\_\_

**VISION:**

- No Vision Problems
- Glasses/contacts prescribed
- Wears glasses/contacts all of the time
- Wears glasses in the classroom only
- Glasses lost/broken

**HEARING:**

- No Hearing Problems
- Frequent ear infections (more than 3/year)
- Has ear tubes - Date Inserted \_\_\_\_\_
- Hearing Loss \_\_\_ Left \_\_\_ Right
- Hearing Aids \_\_\_ Left \_\_\_ Right
- Hearing aids lost/broken

Is your child currently taking any medications (including inhalers)? Yes \_\_\_ No \_\_\_

If yes, please list name and reason for taking the medication:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Medications in School:**

- If your child has **prescription medication** (including inhalers) that they will need during school, please complete the prescription medication consent form. Both the parent/guardian and the child's healthcare provider must sign this form.
- If your child has **over the counter medication** you would like to have available for them at school please complete the over the counter medication form, this form requires a parent/guardian signature.  
\*\*\*All medications must come to school in the original container.
- **Grades 6-12 can self carry and self administer tylenol and ibuprofen** with a completed consent form signed by the parent and the student.
- The above forms may be obtained from school or can be found on the MACCRAY Schools website under departments, then health services.

Form completed by: \_\_\_\_\_

Relationship to student \_\_\_\_\_

Date \_\_\_\_\_