DES MOINES PUBLIC SCHOOL ANNUAL HEALTH REVIEW (ELEMENTARY) SCHOOL YEAR: ____________

CONTACT INFORMATION

Student Name: ______________________ Date: __________ Birth date: ____________ Grade: ________

Parent Info: Mother: Name: ______________________ Home/cell: ______________ Work: ______________
Email: ______________________
Father: Name: ______________________ Home/cell: ______________ Work: ______________
Email: ______________________

HEALTH REVIEW

Breathing Problems	Heart Problems	Psych/Neuro Problems	Eating Problems	Gland Problems	Orthopedic Problems	Chronic/Developmental Problems
___ Asthma	___ Heart Murmur	___ Frequent Headaches	___Ulcer	___ Diabetes	___Broken bones	___ Cerebral Palsy
___ Reactive Airway	___ Heart Surgery	___ Migraines	___ Frequent stomach aches	___ Thyroid	___ Orthopedic braces	___ Downs Syndrome
___ Other Problems	___ Other Problems	___ Dizziness/Fainting	___ Bowel Problems	___ Kidney	___Other Problems	___ Spina Bifida
		___ Seizure	___ Special Diet at school			
		___ ADHD/Autism				
		___ Anxiety/Depression				

Please explain any items checked above: ____

Any Dr. ordered special needs?: ____

Significant allergies: ______________ Treatment: ______________ Medications/Epi-Pen?(***requires Dr. order***) ______________

List any illnesses, operations, or accidents your child has had in the past year: ______________________________

List any emotional, social, or other conditions that might affect your child's performance: ______________________________

List other health concerns you would like the nurse to know about: ______________________________

Has your child lived outside of the United States during the past year? _____ Yes _____ No If yes, name of country: ______________

MEDICATIONS

Current medications taken at home: ______________________________

Current medications taken at school: ______________________________
(medications taken at school require a doctor's order)

EMERGENCY INFORMATION: Doctor name: ______________________ Phone: ______________________
Hospital preference: ______________________

I give permission to the school nurse to share educationally relevant health and emergency information (to included medical diagnosis) with school staff on a need-to-know basis. Parent signature: ______________________ Date: