*Please complete and return with enrollment packet* *2020-2021 ACA HEALTH HISTORY - ALL STUDENTS*

| | |
|---|---|
| Student Name:<br>DOB: | Parent:<br>Legal Guardian: |
| School Year:<br>Grade____<br>Homeroom Teacher:<br>Car#: | Cell Phone:<br>Work Phone:<br>Home Phone:<br>Alt. Contact: Ph. No.: |

Health Insurance for Student: ☐ Medicaid ☐ Health Choice ☐ Private Insurance ☐ No Health Insurance

***Please check any/all boxes below regarding your child's health condition(s). This information will be shared with appropriate school staff to better care for your child during the school hours.***

☐ **My child does not have a current medical condition.**
☐ **My child has suffered a head injury / concussion during the past year.**

| Please check medical conditions(s) your child has NOW: | List all medications your child takes NOW: | Medication(s) to be given at school this year |
|---|---|---|
| ☐ ADHD | | |
| ☐ Allergic to: Wasp Bee Sting Mosquito | | ☐ Epinephrine ☐ antihistamine |
| ☐ Allergic to: _____ Food | | ☐ Epinephrine ☐ antihistamine |
| ☐ Allergic to Latex | | ☐ Epinephrine ☐ antihistamine |
| ☐ Allergic to _____ Medicine | | |
| ☐ Allergic to Seasonal / Environmental: pollen dust cat dog smoke | ☐ Zyrtec ☐ Claritin ☐ Allegra ☐ Nasal Spray | |
| ☐ Asthma | Inhaler: ☐ Preventive ☐ Rescue ☐ Nebulizer Used:_____ | ☐ Rescue inhaler needed for PE ☐ Nebulizer needed at school |
| ☐ Diabetes | ☐ diet ☐ oral med. ☐ Insulin ☐ pump | ☐ diet ☐ glucometer ☐ insulin ☐ pump |
| ☐ Heart Condition, describe: | | |
| ☐ Sickle Cell ☐ Trait Only | | |
| ☐ Seizures / Epilepsy<br>Date of last seizure: _____ | ☐ Diastat ☐ Midazolam ☐ Oral Medication: _____ | ☐ Diastat ☐ Midazolam |
| ☐ Stomach Problems<br>☐ Reflux ☐ IBS ☐ Crohn's<br>Other:_____ | | |
| ☐ Hearing Problems | ☐ Deaf: R L ☐ Hearing Aid: R L | ☐ FM System |
| ☐ Vision Problems | ☐ Glasses ☐ Best Correction ☐ Contacts ☐ Visually Impaired ☐ Blind: R L | ☐ Color Blind |
| Other Medical Conditions: | | |

| **Special Diet Needs at School** | **Special Devices** | **Skilled Procedures** |
|---|---|---|
| *See school nurse for required Diet Order form (to be signed by healthcare provider)*<br>Diet modifications: _____<br>_____<br>_____<br>Reason for modifications: _____<br>_____<br>_____ | ☐ Wheelchair<br>☐ Walking Aid –describe:<br>____<br>_____<br>☐ Special lift device (bathroom assistance)<br>☐ Other:<br>_____ | *See school nurse for Skilled Procedure(s) Form (to be signed by Healthcare provider)*<br>☐ Tube Feeding<br>☐ Catheterization ___Self ___ Staff<br>☐ Tracheostomy Care ___ Suction Machine.<br>☐ Ileostomy ☐ Colostomy<br>☐ Other, please describe_____<br>_____ |

My ☐ child has a medical condition which substantially limits one or more bodily functions that may impact a major life function. I would like to pursue 504 eligibility accommodations for my child. Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act prohibit discrimination against any individual on the basis of a disability.

Parent/Legal Guardian Signature: Date: / /

**Reviewed by: _____ Date: ___/___/___ EAP/IHP sent; ___/___/___ Date Received:___/___/___/**