South Shore Educational Collaborative
Health Form

Student Information:

Name of Student:_____
Street Address:_____
Town/City:_____ **Zip Code:**_____
D.O.B._____
Diagnosis:_____

Please answer the following questions:

1. Is your child currently being treated for any of the following? Please circle "Y" for Yes or "N" for No and provide details where indicated.

Arthritis or Joint Disease	**Y**	**N**	**Heart Disease**	**Y**	**N**
Asthma	**Y**	**N**	**Kidney Disease**	**Y**	**N**
Blood Disorder	**Y**	**N**	**Food Allergy**	**Y**	**N**
Celiac Disease	**Y**	**N**	**Medication Allergy**	**Y**	**N**
Compromised Immune System	**Y**	**N**	**Bee Sting Allergy**	**Y**	**N**
Concussion/Head Injury	**Y**	**N**	**Seizures**	**Y**	**N**
Diabetes	**Y**	**N**	**Behavioral/Soc-Emotional**	**Y**	**N**
Lyme Disease	**Y**	**N**	**Cystic Fibrosis**	**Y**	**N**
Nose Bleeds	**Y**	**N**	**Sleeping Disorder**	**Y**	**N**
Orthopedic Issues	**Y**	**N**	**Other:**		

Please explain any "Yes" answers above and provide more detailed information.

_____

_____

_____

_____

2. Does your child require an EPIPEN? Yes ___ No____
If yes, written physician's orders and the EPIPEN must be provided before your child may start school.

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3. Medications:

Name of Medication	Reason for Medication	Dosage	Time of Day

Does your child require any Medication at school? Yes___ No___
If yes, Parent/Guardian and Prescriber must complete a Medication Administration Form in its entirety and return it to the school nurse.Medications must be delivered to the school by an adult, students may not carry medications other than asthma inhalers and EPIPENS to school.

4. Does your child have a specific dietary requirement that needs to be followed during the school day? Please provide detailed information and specify food allergy vs. diet.

_____

_____

_____

I give the school nurse permission to share the above confidential health information with his/her teacher, specialists, staff on an as needed basis. Yes____ No____

***REMINDER: A copy of your child's current physical and immunization record must be provided annually to the school nurse. If you have any questions, please contact your child's SSEC nurse.**

Signature of Parent/Legal Guardian:_____ Date:_____