Client Health History

(Name of Facility/Owner of Facility) requires the following information to complete your enrollment. Health information you provide about your child is confidential and will be used to provide safe, informed care at school, and will only be communicated to (Name of Facility/Owner of Facility) personnel who require it to better serve your child. **If your child has a medical condition, or medical changes occur during the school year, it is the parent/guardian's responsibility to notify the school nurse and update the information.**

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| **Criteria Description** | **Select One** | **Describe Condition** | |
| **Asthma** | **Yes**  **No** | **List any asthma medications your child is currently taking. Texas law requires a special**  **permission form to carry inhaler** | |
| **Food allergies** |  | **Please list food and describe reaction:** | |
| **Other life-threatening allergies** |  | **Please list any life-threatening allergies and describe reaction:** | |
| **Is you child allergic to any medications?** |  | **Please list all medications your child is allergic to and describe their previous allergic reactions:** | |
| **Does your child have an EpiPen/emergency epinephrine?** |  | **Allergy Action Plan is required for life-threatening allergies.** | |
| **Seizures** |  | **Please Describe:** | |
| **Diabetes** |  | **Diabetes Management & Treatment Plan is required for care at school - see School Nurse.** | |
| **Heart Condition** |  | **Please Describe:** | |
| **Has your child been diagnosed with or treated for ADD/ADHD?** |  | **Please list medications your child is currently taking for ADD/ADHD:** | |
| **Has your child been diagnosed with or treated for a**  **mental health or psychological**  **condition?** |  | **Please Describe your child's condition and list medications currently taken:** | |
| **Other conditions or health issues:** |  | **Please describe.** | |
| **I understand and agree that a representative of Rockwall ISD may provide minor first aid treatment (Caladryl Clear, Burn Free Gel, Lubricating Eye Drops, Cough Drops) pursuant to medical advisor standing orders to my child at school, unless I opt out by typing No in the following boxes:** | | | |
| **Caladryl Clear** | **Yes No** | **Burn Free Gel** |  |
| **Lubricating Eye Drops** |  | **Cough Drops** |  |
| **Signing your name below as a parent or legal guardian which verifies that you have reviewed the above and that you certify that information provided is true and accurate.**  **Parent/Guardian Signature: Date**: | | | |
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