San Dieguito Union High School District

HEALTH INFORMATION FORM

IMPORTANT: PARENT / GUARDIAN & STUDENT SIGNATURES ARE REQUIRED ON PAGE 2 OF THIS FORM

			☐ Male ☐ Female			
STUDENT: Last Name	**First Name**	M. Initial		Date of Birth Month/Day/ Year	Current School	Grade

PARENT/GUARDIAN: The following information is necessary for the student's health record. It is required upon registration of the student. However, **if student develops new health problem/s** in the future, we request that you **notify the school's Health Office as soon as possible** to provide the appropriate care for your student.

HEALTH CONDITION/S:

Please mark the corresponding items that best describe your student's current health condition/s **and return the completed form to school's Health Office.** Please provide specific information regarding conditions that may affect student learning and participation in school activities **(if needed, enclose additional information on a separate sheet).**

HEALTH CONDITION:	EXPLAIN: Please include, date diagnosed, frequency, severity, etc.
☐ Allergy (food, bee sting, medication, other)	☐ **Needs** medication at school *(requires a signed form please see page 2)*
☐ Asthma (indicate: mild, moderate, serious)	☐ **Needs** Inhaler at school *(requires a signed form please see page 2)*
☐ Blood Disorder/s	
☐ Cerebral Palsy	
☐ Diabetes	☐ **Needs** Insulin at school *(requires a signed form please see page 2)*
☐ Diagnosed ADHD / ADD	☐ **Needs** medication at school *(requires a signed form please see page 2)*
☐ Disabilities / Genetic Disorder	
☐ Emotional Disorder	
☐ Fainting	
☐ Heart Condition	
☐ Immune Deficiency Syndrome	
☐ Kidney Disorder	
☐ Migraine Headache	☐ **Needs** medication at school *(requires a signed form please see page 2)*
☐ Neurological Disorder	
☐ Orthopedic Condition	
☐ Prosthesis	
☐ Psychological Disorder	
☐ Scoliosis	
☐ Seizure Disorder	☐ **Needs** medication at school *(requires a signed form please see page 2)*
☐ **Date of last doctor's visit**:	☐ **Other Serious Health Concerns:** (If needed, enclose a separate sheet)

HEARING IMPAIRMENT		
☐ Deaf/Hard-of-Hearing	☐ Right Ear	☐ Left Ear
☐ Hearing Aids	☐ Right Ear	☐ Left Ear
☐ Hearing Problems	☐ Right Ear	☐ Left Ear
VISUAL IMPAIRMENT	☐ Right Eye	☐ Left Eye
☐ Student Wears Glasses	☐ Contact Lenses	
☐ For Distance	☐ Due to Astigmatism	
☐ For Reading	☐ **Other:**	

SPEECH IMPAIRMENT
☐ Has Had Therapy
☐ Needs Therapy
PHYSICAL RESTRINCTIONS
☐ To PE Class Participation
☐ Kind of Restrictions:

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STUDENT: **Last Name** _____ **First Name** _____ M. Initial _____ ☐ Male ☐Female Date of Birth Month/Day/ Year _____ Current School _____ Grade _____

PARENT/GUARDIAN & STUDENT: Students are NOT ALLOWED to carry medication except with physician's authorization on file for; inhalers for asthma, epipen for allergic reaction, and/or glucagon for diabetes AND all other MEDICATION; prescribed, over-the-counter, homeopathic remedies, vitamins, etc. which are to be administered during the school day or during school-sponsored activities, **REQUIRE an Authorization for Administration of Medication form signed by the physician and parent. If your student requires administration of medication during school hours, please visit your school's Health Office or visit the District's website to obtain the required form "Authorization for Administration of Medication" :** www.sduhsd.nett link > Special Education Department > Health Services

Medication/s student currently takes at home (please include prescription date and doses): _____

Does the student take continuing medication? NO☐ **YES** ☐ Will it be necessary to take medication at school? NO☐ **YES** ☐

If the student needs to take medication during school hours: Please complete and personally deliver the signed "**Authorization for Administration of Medication**" form to your school's Health Office:

Carmel Valley	CV	858-481-8221 ext. 3014	*Canyon Crest Academy*	CCA	858-350-0253 ext. 4011
Diegueño	DNO	760-944-1892 ext. 6631	*La Costa Canyon*	LCC	760-436-6136 ext. 6024
Earl Warren	EW	858-755-1558 ext. 4414	*San Dieguito Academy*	SDA	760-153-1121 ext. 5021
Oak Crest	OC	760-753-6241 ext. 3378	*Torrey Pines*	TP	858-755-0125 ext. 2235
Pacific Trails	PT	858-509-1000 ext. 4605	*Sunset*	SS	760-753-3860 ext. 5534

MEDICATION (EC § 49423): Any student who must take prescribed medication at school and who desires assistance of school personnel must submit a written statement of instructions from the physician or physician assistant and a parental request for assistance in administering the medications. Any student may carry and self-administer prescription auto-injectable epinephrine **only if the student submits a written statement of instructions from the physician or physician assistant and written parental consent authorizing the self-administration of medication**, providing a release for the school nurse or other personnel to consult with the child's health care provider as questions arise, and releasing the district and personnel from civil liability if the child suffers any adverse reaction as a result of the self-administration of medication.

CONTINUING MEDICATION REGIMEN (EC § 49480): The parent or legal guardian of any pupil on a continuing medication regimen for a non-episodic condition shall inform the school nurse or other contact person of the medication being taken, the current dosage, and the name of the supervising physician. With the consent of the parent or legal guardian of the pupil, the school nurse may communicate with the physician and may counsel with the school personnel regarding the possible effects of the drug on the child's physical, intellectual, and social behavior, as well as possible behavioral signs and symptoms of adverse side effects, omission, or overdose.

I have read and understand the above statement and Ed Code Requirements:

PARENT:

PRINT: Parent's / Guardian's Name _____ Parent's / Guardian's Email Address _____ Cell/Phone Number _____

Current Address _____ City _____ Zip Code _____

Parent/Guardian _____ **Signature** _____ **Date**

STUDENT:

PRINT: Student's Name _____ Student's Email Address _____ Cell/Phone Number _____

Student _____ **Signature - Adult student: Yes** ☐ **No** ☐ **Date** _____

HEALTH OFFICE:

Initials & Date Received: