

# Student Health Information

**Student Name** \_\_\_\_\_

**DOB:** \_\_\_\_\_

**First**

**Middle Initial**

**Last**

**Student Cell Phone # (If Applicable)** \_\_\_\_\_

**Status**

Re-enrolled FSI Student

New Student

**Primary Doctor Name:** \_\_\_\_\_ **Doctor #:** \_\_\_\_\_

**Does your Child have any of the following Diagnosed Conditions? \* Please PRINT Legibly \***

<p><b>A. DRUG AND FOOD ALLERGIES</b></p> <ul style="list-style-type: none"> <li><input type="radio"/> Penicillin/Amoxicillin</li> <li><input type="radio"/> Latex</li> <li><input type="radio"/> Food Allergy (please specify): _____</li> <li><input type="radio"/> Other: _____</li> <li><input type="radio"/> None</li> </ul>	<p><b>D. METABOLIC/ENDOCRINE</b></p> <ul style="list-style-type: none"> <li><input type="radio"/> Diabetes <span style="float: right;">Requires Insulin? YES or NO</span></li> <li><input type="radio"/> Thyroid Disorder</li> <li><input type="radio"/> Other: _____</li> <li><input type="radio"/> None</li> </ul>
<p><b>B. ALLERGIES/RESPIRATORY</b></p> <ul style="list-style-type: none"> <li><input type="radio"/> Asthma</li> <li><input type="radio"/> Bees</li> <li><input type="radio"/> Seasonal Allergies:</li> <li><input type="radio"/> Allergy to Dog/Cats/Animals</li> <li><input type="radio"/> Other : _____</li> <li><input type="radio"/> None</li> </ul> <ul style="list-style-type: none"> <li>• <b>Does your student require an Epi-pen at school or with him/her for any of the above listed allergies?</b> YES or NO</li> <li>• <b>Does your student require an inhaler at school or with him/her at all times?</b> YES or NO</li> <li>• <b>Are any of these allergies' life threatening? YES or NO</b> <b>IF YES, please write LF next to allergy</b></li> </ul>	<p><b>E. HEAD/NEUROLOGICAL</b></p> <ul style="list-style-type: none"> <li><input type="radio"/> Autism or Asperger's Syndrome</li> <li><input type="radio"/> Cerebral Palsy</li> <li><input type="radio"/> Migraines</li> <li><input type="radio"/> Seizure Disorders <span style="float: right;">If so, list date of Last seizure _____</span></li> <li><input type="radio"/> Spina Bifida</li> <li><input type="radio"/> Tourette's Syndrome</li> <li><input type="radio"/> Traumatic Brain Injury (TBI)</li> <li><input type="radio"/> Other: _____</li> <li><input type="radio"/> None</li> </ul>
<p><b>C. CARDIOVASCULAR</b></p> <ul style="list-style-type: none"> <li><input type="radio"/> Fainting</li> <li><input type="radio"/> High Blood Pressure</li> <li><input type="radio"/> Heart Murmur/Irregular Heart Rhythm</li> <li><input type="radio"/> Other: _____</li> <li><input type="radio"/> None</li> </ul>	<p><b>F. EYES/HEARING</b></p> <ul style="list-style-type: none"> <li><input type="radio"/> Vision Impaired</li> <li><input type="radio"/> Hearing Impaired</li> <li><input type="radio"/> Wears Hearing Aids</li> <li><input type="radio"/> Other: _____</li> <li>None</li> </ul>

- D. BEHAVIORAL OR SOCIAL**
- Anxiety/Panic Attacks
  - Depression
  - Bipolar Disorder
  - Eating Disorder
  - ADD/ADHD
  - OCD
  - PTSD
  - Other \_\_\_\_\_
  - None

**Has your child ever been hospitalized for the any of the condition(s) checked?**

- Yes
- No

If Yes, please list date and reason:

\_\_\_\_\_

\_\_\_\_\_

**Has your child ever stopped breathing or needed CPR? YES or NO**

**Has your child suffered a concussion in the past year? YES or NO**

**Please list all medications (prescription and non-prescription) your student takes: (In case of an emergency, we need this information to share with EMS)**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

**Additional Information:**

**Does your Child need any prescription or non-prescription medication to be given at school? YES or NO**

**If YES, a Medication or Action form must be completed and signed by the parent/guardian and Physician each year. Please refer to our website under the Parents Tab/Forms & Resources for the appropriate forms.**

*As parent or legal guardian of \_\_\_\_\_, I hereby grant permission for any treatment deemed necessary for a condition arising at (THE FRANKLIN SCHOOL OF INNOVATION). Treatment may be given by emergency personnel or a first responder as necessary. I understand every effort will be made to contact me prior to treatment. I also give pertinent (THE FRANKLIN SCHOOL OF INNOVATION) staff permission to obtain and review medical information provided of the above named student, and understand that this information will remain confidential and will only be used in the care and treatment of the above named student.*

Parent/Guardian Name(s): \_\_\_\_\_

Parent/Guardian Signature(s): \_\_\_\_\_ Date: \_\_\_\_\_