admission or access to, or treatment or employment in, its programs and activities.

Tami Cox, BSN, RN
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New Castle Community Schools
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NEW CASTLE COMMUNITY SCHOOL CORPORATION
NEW CASTLE MIDDLE SCHOOL

Student Name: _____

Birth Date: _____ **Grade:** _____ **Phone Number:** _____

Parent/Guardian: _____

Health History: Check all that apply:

☐ ADD/ADHD	☐ Anaphylaxis	☐ Anxiety	☐ Asthma	☐ Behavioral
☐ Hypoglycemia	☐ Hypertension	☐ Seizures	☐ Cystic Fibrosis	☐ Diabetes
☐ Developmental	☐ Gastric	☐ Headache	☐ Hearing	☐ Heart
☐ Kidney	☐ Malignancy	☐ Migraine	☐ Neurological	☐ Psych
☐ Tumor	☐ Urinary	☐ Visual	☐ Other	

Details for any checked above or not listed: _____

_____

_____

Allergies:

Allergy: _____ Severity: _____ Treatment: _____
Allergy: _____ Severity: _____ Treatment: _____
Allergy: _____ Severity: _____ Treatment: _____

Restrictions: (All restrictions require a physician's order on file at the school)

Dietary: ☐ YES ☐ NO Activity: ☐ YES ☐ NO

Details: _____

_____

Diseases:

Has your child had the chickenpox? ☐ YES ☐ NO Month/Year: _____

Medications:

Please fill out medication permission form available in the Health Office regarding any medication to be left at your student's school.

Additional Information:

Please state any additional important health related information:

_____

_____

_____

_____

Acknowledgement

To ensure the health and well-being of my child, I understand that state and federal laws allow pertinent health information to be provided to appropriate school personnel. This will be done only on a "need to know basis" in a confidential manner. I agree to alert the school nurse/health assistant of any changes in my child's medications or health status. I agree to notify the school of any change in phone numbers, addresses, and emergency contacts so that I can be quickly located in case of an emergency.

_____ _____

Parent/Guardian Name **Date**

_____ _____

Parent/Guardian Signature **Relationship to Student**

Concerns/Questions:

Any health related questions or concerns can be discussed with the corporation nursing supervisor or the health assistant at your child's school. Please refer to the contact information above.

Nursing Only:

Reviewed by: _____ Date: _____