**NEW CASTLE COMMUNITY SCHOOL CORPORATION**

**Eastwood Elementary**

**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 Fibros \_\_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 the 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_