# Health Assessment Form

**Student Information**

<table>
<thead>
<tr>
<th>Name of Student</th>
<th>Grade</th>
<th>Sex (F M)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Address</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date of Birth</td>
<td>Age</td>
<td>School last attended/Location</td>
</tr>
<tr>
<td>Mother/Guardian’s Name</td>
<td>Day Phone</td>
<td></td>
</tr>
<tr>
<td>Father/Guardian’s Name</td>
<td>Day Phone</td>
<td></td>
</tr>
<tr>
<td>Dad Cell Phone</td>
<td>Mom Cell Phone</td>
<td></td>
</tr>
<tr>
<td>Physician</td>
<td>Phone</td>
<td>Hospital</td>
</tr>
<tr>
<td>Dentist</td>
<td>Phone</td>
<td></td>
</tr>
</tbody>
</table>

**Emergency Contacts** (in cases when a Parent/Guardian cannot be reached)

1. Name & Day Phone
2. Name & Day Phone

**Health Conditions** (check those that apply)

- [ ] ADD/ADHD
- [ ] Allergies (Life Threatening)
- [ ] Allergies
- [ ] Arthritis/Connective Tissue
- [ ] Asthma/Reactive Airway
- [ ] Behavioral/Emotional/Psychological
- [ ] Blood Disorder
- [ ] Brain/CNS Disorder
- [ ] Cancer
- [ ] Cardiovascular (Heart/Blood Disease)
- [ ] Cerebral Palsy
- [ ] Cystic Fibrosis
- [ ] Developmental Delay
- [ ] Diabetes
- [ ] Eating Disorder
- [ ] Endocrine Disease
- [ ] G.I. Disorder (Stomach/Intestinal)
- [ ] Genetic Disorder
- [ ] Hearing Impaired
- [ ] Migraine Headaches
- [ ] Musculoskeletal Disorders
- [ ] Prosthesis
- [ ] Seizure Disorder
- [ ] Skin Disease
- [ ] Spinal Bifida
- [ ] Urinary/Kidney Disease
- [ ] Visually Impaired

Surgical History/Other (Please List):

- Please fully explain any answers checked above (include severity and symptoms of any allergies)
- Please list any medication(s) the student takes on a regular basis.
- Please list any physical education restrictions if applicable
- Please list any other factors that the school nurse, counselor or your child’s teacher(s) should know of which might affect the student’s school experience.

504 Plan on file? □ YES □ NO

Parent/Guardian Signature

Date
Blue Valley School District  
Student Services  
Consent for Administration of Approved Over-The-Counter Medications

Name of Student ___________________________________________ Grade _________

Please check the medications you would like to be made available to your child:

- Acetaminophen (like Tylenol)
- Ibuprofen (like Motrin or Advil)
- Antihistamines (like Benadryl or Zyrtec for allergy symptoms)
- Lotions, creams or ointments (like Calamine, Cortaid, Bacitracin)
- Throat Lozenges/Cough Drops
- Antacids (like Tums)

Not all of the medications listed below are stocked in every health room

School personnel must have parental consent in order to administer over-the-counter medications. Generic equivalents maintained in the health room may be used in place of more expensive brand-name items. The school nurse or delegated staff person will administer the approved medications as deemed necessary using his/her judgement. **If parents send over-the-counter medications to be administered at school, they must be in the original container accompanied by a note explaining the reason for the medication.**

- Please list any medication(s) the student takes on a regular basis if you have not done so on the opposite page.

- Please list any medication allergies if you have not done so on opposite page: ______________________________

☐ I hereby give permission for my child to receive any medication checked on this form, as deemed necessary by the school nurse or delegated staff person.

*I understand that any school employee who administers these medications according to proper dosages shall not be held liable for damages as a result of an adverse reaction to the medication administered.*

_________________________________________  __________________________
Parent/Guardian Signature                        Date

OR

☐ I **DO NOT** want any medications given to my child at school.

_________________________________________  __________________________
Parent/Guardian Signature                        Date

PLEASE COMPLETE BOTH SIDES OF THIS FORM

BV-112 Revised 3/23/2023