Davenport Community Schools - FORM B
2017-18 Health Services Information

For Office Use
Please detach and forward to the Nurse's Office

Your child's health and comfort are important to us. Please take a moment to describe your child's health needs.
The information provided on this form may be shared with school personnel for the provision of appropriate health and/or educational services. Release of this information will be for the current school year. This release may be revoked at any time with a written request to the school.

Name of Student:_____ Birth Date:_____ Grade:_____

EMERGENCY HEALTH INFORMATION FOR YOUR CHILD

Has your student been **diagnosed by a physician** for: (please circle **YES** or **NO** and **which condition**)

Yes No Asthma/Bronchospasms
Yes No Allergies (food/medication/latex/other)
Yes No Diabetes
Yes No Heart Problems
Yes No Blood Pressure Problems
Yes No Blood Disorders (sickle cell, other)
Yes No Kidney/Urinary problems
Yes No Stomach Problems
Yes No Bowel Problems
Yes No Wheelchair

Yes No Skin Condition
Yes No Neuromuscular
Yes No Skeletal Problems
Yes No Hearing Problems
Yes No Vision/Glasses/Contacts
Yes No Headaches/Migraines
Yes No Seizure Disorder/ Epilepsy
Yes No Speech Problems
Yes No Walk assist

Yes No ADD
Yes No ADHD
Yes No Anxiety
Yes No Bipolar Disorder
Yes No Behavioral Disorders
Yes No Depression
Yes No Other Mental Health Condition (OCD,ODD,RAD,Tourettes)
Yes No Other Health Concerns

Please comment on any "Yes" items above or other necessary information, include any nursing procedures that need to be performed at school: _____

_____

_____

Activity restrictions due to a condition _____

*Current Medications:_____ ❒ Not on Medication
*Please submit a Medication Administration Consent form if these are to be given in school.

Explain any hospitalizations, surgery, serious illness or injury for your child? _____

_____

_____

Proof of screenings are required for children entering Kindergarten, including: Immunizations, Lead Screening, Dental Screening, and Vision Screening.

Name of Doctor & Phone #: _____
Name of Dentist & Phone #: _____
Name of Therapist or Counselor & Phone #: _____

Insurance (check one): ❒ Private Insurance ❒ Medicaid ❒ No Insurance ❒ Other, specify: _____
Please list an Emergency Contact for Nurse to discuss health concerns or emergencies:

Name: _____ Phone #: _____ Student Cell #(if any): _____

_____ _____
SIGNATURE OF PARENT/GUARDIAN **DATE**