Van Buren Community School District
Health Information

Please complete the following information to promote and protect the health of students.

Name of student: ______________________________________ **Grade**: _______ **Age:** _______

Does this student have:

___Yes ___No **Asthma or bronchospasms**
___Yes ___No **ADD/ADHD/Behavioral issues**
___Yes ___No **Heart problems**
___Yes ___No **Blood pressure problems**
___Yes ___No **Kidney/urinary problems**
___Yes ___No **Diabetes**
___Yes ___No **Seizures**
___Yes ___No **Migraine headaches**
___Yes ___No **Depression/Anxiety**
___Yes ___No **Stomach/bowel problems**

Instructions for special health needs: ____

Medication	Dose	Frequency	Diagnosis	Given at school?
				___Y ___N
				___Y ___N
				___Y ___N
				___Y ___N
				___Y ___N

___Yes ___No Does your child have any allergies?

If yes, to what are they allergic? ____

What is the reaction? ___________________ How do you treat the reaction? ___________________

___Yes ___No Has your child had any surgery, serious illness or injury? Please explain.

____

___Yes ___No Does or has your child had any other health or emotional concerns which you feel it would be helpful for the school to know?

____

___Yes ___No Has your child had any recent immunizations?

If yes, please provide the school with an updated copy of your child's immunization record

Date of last physical exam:________ Date of last dental exam:________

Date of last vision exam:________ Wears: (circle) Glasses/Contacts/Hearing Aids

Name/Address/Phone # of child's doctor____

Name/Address/Phone # of child's dentist____

Does student have: ___Private Insurance ___Medicaid ___No Insurance ___Other: _______

Does student have dental insurance? ___Yes ___No

OVER →

Name of Insurance Provider: Medical ____________________ Dental ________________________

If student's health care provider is not available, may we send him/her to another local provider?

___Yes ___No Comments: ____

In case your child is ill or injured at school or during a school event out of town, and we think he/she needs medical attention, do you grant school personnel and/or the above person(s) permission to do so?

___Yes ___No Comments: ____

I have read, signed, and understand the "Medication Administration Authorization" form which explains the administration of prescription and over the counter medications and gives permission. A copy of this form is needed for all medication administration and can be found under "Parent Forms" the school website at: **www.van-buren.k12.ia.us/.**

___Yes ___No Comments: ____

_____________________________________ ___________

Signature of parent/guardian Date

Kindergarten students only:

House File 158 of Iowa Law mandates that each child be screened for lead levels before entering Kindergarten. Was this child tested for lead? ___Yes ___No
Date of screening(s) ____________________ Screening Clinic __________________________

Does this child have an Iowa Department of Public Health Immunization card filled out and up-to-date? ___Yes ___No If no, explain: ____
***Please send a completed copy of immunizations with the child for Kindergarten enrollment.**

If you have questions, please call Sara Sprouse, School Nurse: (319)293-3183 (Jr./Sr. High School)
(641)936-4321 (Elementary)