

**OASIS ELEMENTARY SCHOOL  
HEALTH STATEMENT FOR SCHOOL YEAR 2020-2021  
~CONFIDENTIAL~**

Student's Name \_\_\_\_\_

DOB \_\_\_\_\_

Grade \_\_\_\_\_

**PART I: CURRENT Health Conditions**

	YES	NO
ADD/ADHD		
Allergies:		
<input type="checkbox"/> food _____		<input type="checkbox"/> EpiPen
<input type="checkbox"/> medication _____		<input type="checkbox"/> EpiPen
<input type="checkbox"/> seasonal _____		<input type="checkbox"/> EpiPen
<input type="checkbox"/> environmental _____		<input type="checkbox"/> EpiPen
Assistive Device-wheelchair, walker, etc		
Asthma: (what is your child's trigger?)		
<input type="checkbox"/> exercise induced <input type="checkbox"/> seasonal		
<input type="checkbox"/> environmental <input type="checkbox"/> illness related		
Back/Neck Injury or Condition		
Blood Clotting Disorder		
Bone/Joint/Muscle Problems		

	YES	NO
Cancer/Leukemia		
Diabetes		
Dietary Restrictions		
Headaches/Migraines		
Heart Problems/Defect		
Hearing Issues or Aids/Ear Problems		
Kidney/Urinary/Elimination issues		
Neurological Problems		
Nosebleeds		
Physical/Activity Restrictions		
Seizures/Epilepsy		
Stomach/Bowel/Elimination issues		
Surgeries		
Vision - Glasses/Contacts		

Please give details for all conditions that are marked "yes" above. \_\_\_\_\_

**PART II: CURRENT Medications**

Please list any medication that the student takes on a routine basis. \_\_\_\_\_

**\*\* If this medication is required during school hours, the parent must obtain the necessary forms from the clinic. \*\***

**PART III: Consents and Signature**

I give my permission for the school nurse to contact my child's doctor if medically necessary.

Pediatrician's Name/Practice \_\_\_\_\_

**\*\*I UNDERSTAND THE FOLLOWING:**

- In order to provide the safest environment and most complete educational program for my child, it is my responsibility to inform the school of any health conditions that may impact my child's learning, return authorization forms and supply needed medications. Refusal may interfere with necessary medical treatment.
- If treatment/procedure cannot be scheduled other than during school hours, a physician order for treatment with parent authorization must be on file with the nurse. The treatment/procedure may be administered by non medical persons trained by the school nurse.
- Medications of any kind including cough drops are not allowed on school grounds without the proper medical authorization on record. School staff including the nurse, MAY NOT administer or assist with any medications without the proper medical authorization on file. Students are not allowed to carry any medications for the safety of our students.
- For the safety of my child, the school nurse may need to share information about my child's health condition with the appropriate school staff including the transportation department. This will be done in a confidential manner and only if required to provide a safe environment for your child. If you do not wish that information shared, it must be requested in writing and filed with the school nurse.
- In the event of serious illness or accident, I give permission to have my child evaluated or treated by EMS or moved by ambulance or other conveyance to a hospital for immediate attention, and I assume responsibility for payments of same.
- Health screenings are done for students in Kindergarten, 1<sup>st</sup>, 3<sup>rd</sup> and 6<sup>th</sup> grades as well as for the MTSS and ESE programs, if needed. These screenings may include height, weight, hearing, vision, and scoliosis checks. I will be notified if the school believes a doctor should be consulted for further examination.  I do **NOT** want the school to screen my child at this time.

Parent/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_