

# HIGHLANDER ACADEMY

## REQUIRED ANNUAL HEALTH STATUS FORM

SCHOOL YEAR: **2022 - 2023**

In order to plan for your child's health care needs during school hours we need current health information. Please complete and return to the Highlander Academy office at the time of registration. Your child's health information may be shared with school staff as needed.

<b>Student</b>		<b>Grade</b>
<b>Birth Date</b>	<b>Age</b>	<b>Gender</b> <input type="checkbox"/> Male <input type="checkbox"/> Female
<b>Parent/Guardian/Emergency Contacts</b>	<b>Relationship</b>	<b>Phone</b>
<b>Call 1st</b>		<b>Home:</b> _____ <b>Cell:</b> _____
		<b>Work:</b> _____
<b>Call 2nd</b>		<b>Home:</b> _____ <b>Cell:</b> _____
		<b>Work:</b> _____

**Student's doctor/healthcare provider:** \_\_\_\_\_ **Phone:** \_\_\_\_\_  
**Student's dentist:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**INDICATE IF STUDENT HAS BEEN DIAGNOSED WITH ANY OF THE FOLLOWING:**

<b>Health Condition</b>	<b>Yes</b>	<b>No</b>	<b>Explanation if "Yes"</b>
<b>Severe Allergies (that require emergency medical intervention)</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Check type of allergy(s) that apply:</b> <input type="checkbox"/> Medication <input type="checkbox"/> Food <input type="checkbox"/> Bees/Insects <input type="checkbox"/> Other
			<b>Identify specific allergy(s):</b> _____
			<b>Does your child require an Epipen?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Asthma</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Date of last asthma attack:</b> _____
			<b>Medication for asthma:</b> _____
			<b>Does your child need this medicine at school?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Diabetes</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Type 1 (Insulin Dependent) <input type="checkbox"/> Type 2 (Oral medication) or <input type="checkbox"/> Prediabetes
			<b>Medication for diabetes:</b> _____
			<b>Does your child need this medicine at school?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Seizure Disorder</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Date of last seizure:</b> _____
			<b>Medication for seizures:</b> _____
			<b>Does your child need this medicine at school?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Heart Condition</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Specify:</b> _____ <b>Treatment:</b> _____
<b>Hemophilia/Bleeding Disorder</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Specify:</b> _____ <b>Treatment:</b> _____
<b>Bowel/Bladder Issues</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Specify:</b> _____
<b>Migraine Headaches</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Triggers:</b> _____ <b>Treatment:</b> _____
<b>Bone/Muscle Problems</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Specify:</b> _____ <b>Activity Restrictions:</b> _____
<b>ADD/ADHD</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Medication for ADD/ADHD:</b> _____
<b>Wears Glasses/Contacts</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Glasses <input type="checkbox"/> Contacts → <input type="checkbox"/> For Distance <input type="checkbox"/> For Reading
<b>Other Serious Illness or Injury</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Specify:</b> _____ <b>Date of Onset:</b> _____
<b>Medication (Prescription or OTC) taken on a regular basis</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>List (if not already listed above):</b> _____ _____
<b>Mental Health Behavioral Issues</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Specify:</b> _____ <b>Treatment/Medication:</b> _____
<b>Hearing Loss</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Hearing Loss Right Ear <input type="checkbox"/> Hearing Loss Left Ear
			<b>Does your child wear a hearing aid(s)?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No

\*Please contact the school office of any change(s) in medication and/or health status of your child.

**Please complete reverse side of Health Form:**

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The only medications that Highlander Academy may dispense at school are those provided to the school by parents. If your child requires medication that may need to be dispensed at school, please list the medications below. This medication must be provided to the office clearly labelled and with written dosage instructions from the parents.

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**Medication to be dispensed by Highlander Academy:**

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*If a student needs to carry medications such as insulin pens or Epi-pens on their person, then please indicate these below. Otherwise, no student is allowed to carry medication at school, and doing so will result in disciplinary measures.*

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**Medication in Student's Possession:**

**Dosage Instructions:**

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**No student is allowed to share medication with other students!**

**Additional Notes or Comments:**

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Parent/Guardian Signature

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Printed Name

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Date