T.R.U.T.H. Preparatory Academy

# 2016 - 2017 School Year Annual Health Information

## Part 1: PLEASE PRINT LEGIBLY

**Student's Legal Name** Last: _____ First: _____ Middle: _____

Birthdate: ____ / ____ / _____ Ethnicity: _____ Gender: _____ Grade: _____ Home Phone: (_____)_____

Address: _____
Street Apartment # City State Zip Code

| | |
|---|---|
| **Parent or Guardian 1:** Relationship to Student:_____<br>Last _____ First _____<br>Cell Phone (____) _____ Work Phone (____) _____<br>Place of Employment: _____<br>Email: _____<br>Legal Guardian: ____Yes ____ No Child Lives With: ____Yes _____ No | **Parent or Guardian 2:** Relationship to Student:_____<br>Last _____ First _____<br>Cell Phone (____) _____ Work Phone (____) _____<br>Place of Employment: _____<br>Email: _____<br>Legal Guardian: ____Yes ____ No Child Lives With: ____Yes _____ No |

**In Case of Emergency** *(Two Contacts who would care for this child in case a parent or guardian cannot be reached)*

| | |
|---|---|
| **Contact 1:** Relationship to student: _____<br>Last _____ First _____<br>Cell Phone (____) _____ Work Phone (____) _____<br>Place of Employment: _____<br>Email: _____ | **Contact 2:** Relationship to student: _____<br>Last _____ First _____<br>Cell Phone (____) _____ Work Phone (____) _____<br>Place of Employment: _____<br>Email: _____ |

**HEALTH CONCERNS:** Please **X** and explain if your child has any of the following

*** Complete action plan for starred conditions.**

_____ **No health concerns**
_____ Allergies* to _____; reaction_____
_____ Food Intolerance to _____; reaction _____
_____ Feeding Difficulties _____
_____ Asthma*: _____
_____ Diabetes*: ▫ Type 1 ▫ Type 2 Managed by: ▫ Diet/Activity ▫ Oral meds ▫ Insulin injections ▫ Pump
_____ Seizures*: type/description/frequency _____
_____ Heart Condition _____
_____ Concussion / Traumatic Brain Injury - date _____
_____ Social/emotional/behavioral/mental health concerns _____
_____ Recent surgeries, hospitalizations, injuries _____
_____ Activity Restrictions _____
_____ Implanted Devices _____
_____ Special Education ▫ / 504 Plan ▫
_____ Bowel / Bladder Concerns _____
_____ Other Health Concern _____
_____ My child has health insurance _____ (▫ I request assistance to obtain this)
Preferred Hospital in the event of an emergency _____

**MEDICATIONS:** List **ALL** medications that this student takes, both at home and at school.

| Medication Name | Dose | Purpose | How Often | Given during school? |
|---|---|---|---|---|
| | | | | |
| | | | | |

***Complete a Medication Administration in School Form for any medication needing to be administered during school hours***

*I attest to the information provided and give permission for its confidential exchange for use in meeting my child's health and educational needs in school. I acknowledge that it is my responsibility to inform the school of any changes to the health status of this student including health conditions, needs, medications, and/or allergies.*

_____ _____ _____
**Parent/Guardian Printed Name** **Parent/Guardian Signature** **Date**

## PROVIDER INFORMATION:

| | Name | Location | Phone / Fax |
|---|---|---|---|
| Primary Health Care Provider | | | |

| | | | |
|---|---|---|---|
| Specialist _____ | | | |
| Dentist | | | |

**Part 2: HEALTH EXAMINATION:** To be completed by child's healthcare provider

Date of last physical exam: _____

**Indicate Normal (N) or Abnormal (AB) - include comments below if AB**

| | N | AB | | N | AB | | N | AB | | N | AB |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Eyes | | | Genitourinary | | | Extremities | | | Neurological | | |
| Ears | | | Gastrointestinal | | | Abdomen | | | Heart | | |
| Nose | | | Feet | | | Skin | | | Lungs | | |
| Throat | | | Spine | | | Endocrine | | | Lymph | | |

Comments:

_____

_____

**Vision / Hearing**

| Vision | | Hearing | |
|---|---|---|---|
| **Date of Last Exam** | | **Date of Last Exam** | |
| **Exam Method** | | **Exam Method** | |
| **Vision Impairment / Correction** | | **Hearing Impairment / Correction** | |

**Please complete diagnosis / ICD-10-CM codes for all health conditions for this child**

| Diagnosis | ICD-10-CM Code |
|---|---|
| | |
| | |
| | |
| | |

**Provider Name** _____ **Location** _____

**Provider Signature** _____ **Phone / Fax** _____

**Date** _____