أكاديمية جيمس الأمريكية – أبوظبي
GEMS American Academy
ABU DHABI

HEALTH INFORMATION

TO BE COMPLETED BY PARENT OR GUARDIAN EACH SCHOOL YEAR

PART 1 Parent or Guardian To Complete: Parent or guardian is encouraged to participate in the development of an Individual Health Care Plan if needed.

Student's Name Last	First	Middle	Sex ☐ M ☐ F	DOB

School Year	Grade	Teacher's Name

Home Phone	Father's Cell Phone	Mother's Cell Phone

My child has a medical condition that may affect his or her school day ☐ NO ☐ YES (please complete Part 2)

____
Parent's or Guardian's Name (Print or Type)

______________________________ ______________
Parent's or Guardian's Signature Date

PART 2 Complete All Boxes That Apply To Your Child: Parent or guardian is responsible for providing the school with any medication, special food, or equipment that the student will require during the school day. Check with the school clinic to obtain correct medication and procedural forms. If an Individual School Health Care Plan is indicated, the parent or guardian is responsible for providing the school nurse with necessary medical information and correct authorization forms.

☐ ALLERGIES (complete EpiPen Authorization form if needed)

Allergy Type:
☐ Food List food(s) ______________________________
☐ Medication List medicine(s) ______________________________
☐ Bee sting ______________________________
☐ Other (list) ______________________________

Reactions
☐ Coughing ☐ Hives ☐ Rash
☐ Difficulty breathing ☐ Local swelling ☐ Wheezing
☐ Generalized swelling ☐ Nausea ☐ Other ______________

Currently prescribed treatments to be used *IN SCHOOL*
☐ Oral antihistamine (Benadryl, etc.) ☐ EpiPen ☐ Other ______________

☐ ASTHMA / REACTIVE AIRWAY DISEASE (complete Inhaler Authorization form if needed)

Triggers ☐ Exercise ☐ Environmental ☐ Other (list) ______________
Physical Education Restrictions ☐ None ☐ Self-limits ☐ Other ______________
Symptoms or reactions
☐ Chest tightness, discomfort, or pain ☐ Difficulty breathing ☐ Throat itch, tightness, or soreness
☐ Coughing ☐ Hoarseness ☐ Wheezing
☐ Other ______________________________

Currently prescribed treatments to be used *IN SCHOOL*
☐ Inhalers ☐ Oral antihistamines ☐ Oral steroids
☐ Nebulizer ☐ Oral bronchodilator ☐ Peak flow monitoring

Date of last hospitalization related to asthma ______________

☐ DIABETES (complete Procedure Authorization form if needed)

Currently prescribed treatments to be used *IN SCHOOL*
☐ Insulin ☐ Syringe ☐ Pen ☐ Pump
☐ Blood sugar testing
☐ Glucagon
☐ Oral medication(s) List medication(s) ______________________________

Is special scheduling of lunch or Physical Education required? ☐ NO ☐ YES

CONTINUE TO PAGE TWO

☐ Seizure Disorder

Type of seizure

☐ Absence (staring, unresponsive) ☐ Complex partial ☐ Generalized tonic-clonic (grand mal, convulsive)

☐ Other (explain) ______________________

Physical education restrictions: ☐ NO ☐ YES

Medications needed *IN SCHOOL* ☐ NO ☐ YES List medication(s) ______________________

Date of last seizure ______________________ Length of seizure ______________________

☐ Other Health Conditions

☐ Cancer ☐ Heart condition (be specific) ______________________

☐ Hemophilia ☐ Physical disability (be specific) ______________________

☐ Respiratory (be specific) ______________________

Other (explain) ______________________

Physical education restrictions ☐ NO ☐ YES

Medication needed *IN SCHOOL* ☐ NO ☐ YES List medication(s) ______________________

Special procedures (e.g. catheterization, cardiac monitor, etc.) required *IN SCHOOL* ☐ NO ☐ YES

(explain) ______________________

☐ Vision Conditions

☐ Contacts ☐ Glasses

☐ Other ______________________

☐ Hearing Conditions

☐ Hearing aid(s)

☐ Other ______________________

PART 3 School Public Health Nurse To Complete if parent or guardian indicates medical condition(s).

☐ Health condition noted

- ☐ Follow protocol (school health care emergencies–suggestion for temporary care manual)
- ☐ Medical flag
- ☐ Individual health care plan or procedure

______________________ Public Health Nurse's Signature

______________________ Date

Notes ______________________

Information from the Fairfax County Public Schools student scholastic record is released on the condition that the recipient agrees not to permit any other party to have access to such information without the written consent of the parent, guardian, or the eligible student.

RETURN COMPLETED FORM TO SCHOOL CLINIC AS SOON AS POSSIBLE