Health Inquiry Form 2018–2019

This form must be completed by all parents each year prior to their child's first day at Post Oak.

The POST OAK SCHOOL

PRINT student name: _____

Entering grade/level in fall: _____ Teacher: _____ Date of birth: _____ Current weight: _____

Check ALL that apply, and take the required Action/Care/Management Plan(s) to medical provider to complete.

☐ **Asthma** ☐ Intermittent ☐ Exercise induced ☐ Uses an inhaler ..... *Asthma Action Plan* required

☐ **Diabetes** ☐ Type 2 ☐ Type 1 ☐ Uses a pump/insulin ..... *Diabetes Management Plan* required

☐ **Seizure** Type: _____ ..... *Seizure Care Plan* required

☐ **Allergies** ☐ Food ☐ Insect ☐ Latex ☐ Medication ..... *Allergy Care Plan* required

List allergen(s): _____

Treatment prescribed: ☐ None ☐ Antihistamine ☐ Epinephrine Auto-injector: _____

If you checked ANY of the above conditions (asthma, diabetes, seizure, allergies), a care plan for each and back-up medication MUST be provided to the school. The care plan must be completed and signed by the medical provider and signed by the parent. Submit to the Nurse's Office with the required back-up medications as indicated below:

☐ **Inhaler:** Two (2) inhalers;
☐ **Epinephrine:** Two (2) auto-injectors;
☐ **Diabetes:** All diabetic supplies, including pump supplies, Glucagon, and insulin pen;
☐ **Seizure:** Two doses of emergency medication for prolonged seizure as prescribed by medical provider.

ADDITIONAL MEDICAL INFORMATION

☐ History of concussion: Date occurred _____ Cleared by medical provider ☐ Yes ☐ No

☐ Hospitalizations during the past 12 months: _____

☐ Existing illnesses: _____

☐ Previous illnesses and injuries. Please include any chronic conditions not listed above, special healthcare needs (e.g. any speech, OT, or physical therapy they may receive), medical devices they may rely on, etc.

This form, completed and signed, along with care plan(s), is required for treatment of above checked health concerns and administration of required medications.

DAILY MEDICATIONS

Please list all medications your child takes regularly, whether they are administered at school or at home (any medication prescribed for continuous, long-term use):

Medication: _____ Dose: _____ Route: _____ Frequency: _____

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Medication: _____ Dose: _____ Route: _____ Frequency: _____

Additional medications or notes you would like us to know:

Parent/guardian signature Date

Physician signature *(**required** for students new to The Post Oak School)* Date

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