Buckeye Union School District

CONFIDENTIAL - STUDENT HEALTH INFORMATION

Student's Name: ______ Birth date: ______ Teacher: ______ Grade: ______

□ Blue Oak/Montessori, 530-676-0164 x1830, Fax: 530-676-0758
□ Buckeye, 530-677-2277 x1230, Fax: 530-672-1483
□ Camerado, 530-677-1658 x1530, Fax: 530-677-9537
□ Oak Meadow, 916-933-9746 x2130, Fax: 916-933-9784
□ Silva Valley, 916-933-3767 x2730, Fax: 916-933-6389
□ William Brooks, 916-933-6618 x2430, Fax: 916-933-391
□ Rolling Hills, 916-933-9290 x3030, Fax: 916-939-7454
□Valley View, 530-677-2261, Fax 916-934-0920

Parent/Guardian: To best plan for your child's health and wellbeing, please complete front (and back if applicable) of form. Medications required during the school year require a separate medication form that should be updated yearly.

MEDICAL HISTORY – *If YES to any *, please complete the REVERSE side of form* (Complete section below).**

Has your child experienced?	***No***	***Yes-within 12 months***	***Has your child experienced?***	***No***	***Yes-within 12 months***	***Has your child experienced?***	***No***	***Yes-within 12 months***
**Allergies			Diabetes-***ask for packet***			Headaches		
*Asthma			Dizziness			*Heart Disease		
*Blood Disorder or Hepatitis			*Epilepsy or Seizures			Nosebleeds		
*Cardiac/Heart Condition			Ear/Eye or Hearing or Vision Problem			*Treatment required (i.e. catheter, etc		
Cerebral Palsy			Fainting Spells					

OTHER MEDICAL CONDITION: ______

Allergy Information

ALLERGIES (please list and complete SEVERE section if applicable): ______

MILD/MODERATE ALLERGIES- Action for MINOR reaction, if symptoms is/are: ______

Provide the following action: ______

If severe allergies: What specific reaction does your child have? Include concerns for airway (irritation, tightness of throat/chest, cough, hoarse, shortness of breath, coughing, wheezing, difficulty breathing), cardiac (fainting, pale, blueness, thready pulse), oral (itching, tingling, swelling of lips, tongue or mouth), skin (hives, itch, rash, swelling – include location), gastrointestinal (nausea, abdomen pain, cramps, vomiting, diarrhea) or other reaction. ***Include DATE of last reaction***

______

SEVERE ALLERGIES- Action for SEVERE reaction, if symptom(s) is/are: ______

Provide the following action: ______

Any previous history of hospitalization, serious illness, accident or surgery: ______

Does your child require any medication(s) while at school (IF YES please obtain medication form): YES ______ NO ______

Does your child require any vision or hearing equipment? ______

Birth History: My child was born ___ Full-Term ___ Premature (if so, at how many weeks? ______) Birth weight: ___

Delivery: Were there any problems? ______

Did baby go home with parent(s)? YES NO Was baby hospitalized after birth? ______

Developmental: Indicate child was (E)arly, (L)ate or (A)verage for milestones: _____Sitting _____Walking _____Talking _____Toileting

Parent/Guardian Name: ______ Phone #: ______

Alternate Emergency Contact: ______ Phone #: ______

Physician's Name and Contact information: ______

Parent Signature: ______ Date: ______

Buckeye Union School District – Individualized Student Health Plan
Asthma, Blood Disorder, Cardiac/Heart Condition, Epilepsy/Seizure Disorder, Treatments Required at School
For students with Diabetic concerns, please obtain and complete the Diabetic Packet at the Health Office prior to school.

Medical condition above or treatment(s) to be addressed in health plan: ______________________________

For any health concerns not listed that you feel may require a health plan, please complete the OTHER section.
IF ADDITIONAL ROOM IS REQUIRED, PLEASE USE A SEPARATE SHEET AND ATTACH IT TO THIS FORM FOR REVIEW.
*****FOR SEVERE ALLERGIES** Please complete front of form section marked ALLERGIES…***

Asthma: Student has ❑ mild, ❑ moderate, ❑ SEVERE asthma. ❑ Inhaler at school, ❑ Inhaler at home, ❑ Inhaler both locations. ❑ Student wears a medical bracelet.

Triggers to asthma include: ______________________________

Any restrictions or special care required, including medications: ______________________________

Blood Disorder: Type of condition: ______________________________

Any restrictions, special care required, or medications: ______________________________

Cardiac/Heart Condition: Type of condition: ______________________________

Any restrictions, special care required, or medications: ______________________________

Epilepsy/Seizure Disorder: Type of condition: ______________________________

Any restrictions, special care required, or medications: ______________________________

Treatments Required at School (include details of medical condition)**:** ______________________________

OTHER: Type of condition: ______________________________

Any restrictions, special care required or medications: ______________________________

EMERGENCY PLAN: Please indicate approval of emergency care for any signs of severe distress: Airway (irritation, tightness of throat/chest, cough, hoarse, shortness of breath, coughing, wheezing, difficulty breathing), Cardiac (fainting, pale, blueness, thready pulse), oral (itching, tingling, swelling of lips, tongue or mouth), gastrointestinal (vomiting blood, bloody diarrhea).

Other condition warranting 911 call: ______________________________

Plan of Action:
1) Contact 911 – do not hesitate to ask for advanced life support
2) Provide basic first aid & CPR as required
3) Call Parent/Guardian and/or emergency contacts listed on previous page & District Nurse
4) Other: ______________________________

Parent Signature: ______________________________ Date: ______________