

**OASIS ELEMENTARY CHARTER SCHOOL  
HEALTH STATEMENT FOR SCHOOL YEAR 2008-2009  
~CONFIDENTIAL~**

Student's Name \_\_\_\_\_

DOB \_\_\_\_\_

Grade \_\_\_\_\_

**PART I: Student Health Status**

Complete the following checklist by indicating any of the following current conditions.

	YES	NO		YES	NO
ADD/ADHD			Hearing Aid/Aids		
Allergies to medication			Heart Problems/Defect		
Allergies to food			Kidney/Urinary Problems		
Allergies to other			Nosebleeds		
EpiPen Kit			Seizures/Epilepsy		
Asthma			Stomach/Bowel Problems		
Back/Neck injury or condition			Vision Problems		
Blood/Clotting disorder			Glasses/Contacts		
Bone/Joint/Muscle problems			Activity/Physical Restrictions		
Cancer/Leukemia			Assistive Device-w/c, walker, etc.		
Diabetes			Any Precautions		
Ear problems/Surgery (tubes)			Dietary Restrictions		
Elimination toileting problems			Significant Family concerns		
Headaches/Migraines			Surgery		
Hearing deficit			Other		

Please give details below for all that are marked YES above. Include a separate sheet if additional details are necessary.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PART II: Current Medications**

Please list any medication that the student takes on a routine bases. Include dosage, reason and frequency below:

\_\_\_\_\_

\_\_\_\_\_

**\*\* If this medication is required during school hours please obtain the necessary forms at registration or from the nurse. \*\***

**PART III: Consents and Signature**

I give my permission for the school nurse to contact my child's doctor if medically necessary.

My Child's doctor is \_\_\_\_\_ Contact number is \_\_\_\_\_

I understand that in order to provide the safest environment and most complete educational program for my child, the school needs to be informed of any health or medical conditions that may affect my child's school day or impact their learning.

I understand that medications of any kind including cough drops are not allowed on school grounds without the proper medical authorization on file. I understand that school staff, including the nurse, MAY NOT administer or assist with any medications without the proper medical authorization on file.

I understand that for the safety of my child, or to provide for their educational program, the school nurse may need to share information about my child's condition with the appropriate school staff. This will be done in a confidential manner. If I do not wish that information shared, I must request this in writing and file it with the school nurse.

I accept responsibility for notifying the school of any change in the health status of my child. In the event of serious illness or accident and I cannot be immediately contacted, I give permission to have my child moved by ambulance or other conveyance to a doctor's office or hospital for immediate attention, and I assume responsibility for payments of same.

Parent/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_