SPERO Academy

2019 - 2020 School Year Annual Health Information

Part A: Front & back to be completed by parent / guardian

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:_____ Last _____ First _____ Cell Phone (___)_____ Work Phone (___)_____ Place of Employment: _____ Email: _____ Legal Guardian: ___ Yes ____ No Child Lives With: ___Yes ___ No Emergency Contact Name: _____ Cell Phone (___)_____ Work (___)_____	**Parent or Guardian 2:** Relationship to Student:_____ Last _____ First _____ Cell Phone (___)_____ Work Phone (___)_____ Place of Employment: _____ Email: _____ Legal Guardian: ___ Yes ____ No Child Lives With: ___Yes ___ No Emergency Contact Name: _____ Cell Phone (___)_____ Work (___)_____

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

I attest to the information provided on both pages. 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. I understand and agree that this student may receive a routine screening for any vision and hearing deficiencies. I will comply with all school illness and medication policies. Furthermore I give permission for school health staff to confidentially exchange health information - both within the school as well as with outside health care providers - for use in meeting this student's health and educational needs in school.

_____ _____ _____
Parent/Guardian Printed Name (s) Parent/Guardian Signature Date

Part A continued

Student's Legal Name:_____ **Birthdate:**_____ **Grade:**_____

PROVIDER INFORMATION:

	Name	Location	Phone / Fax
Primary Health Care Provider			
Specialist _____			
Dentist			

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

Medication Name **Dose** **Purpose** **How Often** **Given during school?**

_____

_____

_____

_____

Guardian and Health Care Provider must complete a Medication Administration in School Form for any medication needing to be administered during school hours

Part B: To be completed by child's healthcare provider

Date of last physical exam: _____

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 _____