SPERO Academy

2020 - 2021 School Year Annual Health Information

Part A: Parent / guardian complete all of Part A and sign.

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:_____	**Parent or Guardian 2:** Relationship to Student:_____
Last _____ First _____	Last _____ First _____
Cell Phone _____ Work Phone _____	Cell Phone_____Work Phone_____
Email: _____	Email: _____
Employed by: _____	Employed by: _____
Legal Guardian: ___ Yes ____ No Child Lives With: ___Yes ___ No	Legal Guardian: ___ Yes ____ No Child Lives With: ___Yes ___ No

1. Emergency Contact Name: _____ Cell # _____Work # _____

2. Emergency Contact Name: _____ Cell # _____ 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 _____
_____ 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 _____
_____ Bowel / Bladder Concerns _____
_____ Other Health Concern _____
_____ Health insurance (please name) _____
_____ Medical Assistance prescriber # _____

Preferred Hospital in the event of an emergency _____

PROVIDER INFORMATION:

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

Part A continued **Student's Legal Name:**_____ **DOB:**_____ **Grade:**_____

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

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 acquire & 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 B: To be completed by child's healthcare provider

Date of last physical exam: _____ **Height** _____ **Weight** _____

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 _____