

Student Health Information Sheet

Manchester, Poplar Grove, Capron, Upper Elementary, Middle School, High School

Date of Registration: (Fecha de Registracion) _____ Grade of Student(Grado del Estudiante) _____

Name: _____
 Last (Apellido) First (Nombre) Middle

Address: _____
 Street (calle) P.O. Box

 City (Ciudad y Estado) State Zip

Personal: _____
 Birth Date (Fecha de nacimiento) Sex

 Father's Name(Nombre Padre) Mother's Name(Nombre Madre)

Health History to be Completed and Signed by Parent/Guardian

Historial De Salud Paraser Completado Y

Diagnosis of Asthma?Diagnosis de Asma? Wheezing/Cough with activity?Ronquido ?	Yes/No Yes/No	Loss of One of Paired Organs? Perdida De uno los pares deOrganos?	Yes/No
Carry Inhaler? Carga Inhalador? Type _____	Yes/No	Hospitalizations?Hospitalizaciones? For What&When _____	Yes/No
Birth Defects? Defectos de Nacimiento? Specify _____	Yes/No	Surgery? Cirugia? For What & When _____	Yes/No
Developmental Delay?Retrasos del Desarrollo?	Yes/No	Serious Injury or Illness? Enfermedad o heridas serias?	Yes/No
Blood Disorders? _____ ProblemasDeLaSangre?	Yes/No	TB Skin Test Positive? Prueba positive dela piel para el TB?	Yes/No Yes/No
Diabetes?	Yes/No	Tobacco Use? Uso de Tabaco?	Yes/No
HeadInjury/Concussion? Herida de la Cabeza?	Yes/No	Alcohol/DrugUse? Uso de Alcohol? Drogas?	Yes/No
Seizures?Convulsiones?_____	Yes/No	Family History of Sudden DeathBefore Age 50?___Historial Familiar de Muerte repentina antes de los 50 anos?	Yes/No
Heart Problems/Short of Breath? Problemas Cardiacos/Falta de Respiracion?	Yes/No	Dental:Braces/Bridge/Plate? Ganchos/Puente/Placa?	Yes/No
Heart Murmur/High BP? Soplo Cardiaco/Presion Arterial Alta?	Yes/No	Dental: Other Otro?	Yes/No
Dizziness/Chest pain with Exercise? MareosO Dolor DePecho Al Hacer Ejercicio?	Yes/No	Medication Taken? Medicinas?	Yes/No
Bone/Joint Problems/Injury?Problemas de los huesos?	Yes/No	Allergies?Alergias?_____	Yes/No
Scoliosis? Escoliosis?	Yes/No	AnyotherConcerns?	Yes/No
Ear/Hearing Problems?Problemas de Audicion?	Yes/No	Otras Preocupaciones?	Yes/No
Eye/Vision Problems? Glasses/Contacts Last Exam Problemas de ojos/vista? Lentes/Contactos examen	Yes/No		

Health History Continued: Historial de Salud :

HealthCondition(s): Condiciones de salud;	Additional comments: Cometarios adicionales
Any medication taken at home? Medicinas tomadas en casa?	No Yes: List
Any medication taken at school? Medicinas tomadas en la escuela?	No Yes-- List:

By initialing below:

I acknowledge that if the emergency care of my child involves medication, I have filed a _____ School Medical Authorization Form (7:270-E) with the school nurse.

Reconozco que si el cuidado de emergencia mi nijo/hija involucra medicamentos, yo he llenado una forma de Autorizacion Medica Escolar con la enfermera de la escuela.

I authorize the School District, and its employees and agents, to take the action they believe is _____ appropriate in an emergency.

Autorizo al Distrito Escolar, y sus empleados y agente, para que tomen la accion que ellos crean apropiada en una emergencia.

I agree to indemnify and hold harmless the School District, and its employees and agents, against _____ any claims, except a claim based on willful and wanton conduct, arising out of the emergency care of my child.

Estoy de acuerdo de indemnificar y mantener sin dano al Distrib o Escolar, y sus empleados y agentes. Contra cualquier reclamo,.excepto un reclamo basado en conducta sin sentido, que surja a raiz del cuidado de emergencia de mi hijo/hija.

_____ I authorize this health information to be shared with appropriate school staff.

Autorizo que esta informacion de salud sea compartida con el personal escolar apropiado.

Does your child have school insurance? Yes No

Tiene aseguranza escolar su hijo/hija.? Si No

Is your child covered by other insurance? Yes No

Su hijo/hija tiene cobertura por otra azeguranza? Si No

If yes, identify the company and insurance number _____

Si tiene, identifiaue ala compania y numero de poliza _____

Parent(s) / Guardian(s) Printed Name

Parent(s) / Guardian(s) Signature

Date / Fecna