STUDENT HEALTH PROFILE

Name: _____ Birthdate: _____

Gender: male female Grade: _____

Health Care Provider Information:

Physician / Clinic: _____

Medical Insurance (circle one): None Oregon Health Plan / Healthy Kids Medicare Private

Dental Insurance: Yes No Vision Insurance: Yes No

May we release your contact info to agencies that provide services you may qualify for? Yes No

Student Health Information:

Life Threatening Allergies (food, insects, etc): _____

Usual reaction to above allergens: _____

Usual treatment of above allergic episode: _____

_____

Does your child have an Epi-Pen? Yes No

Chronic Medical Conditions (diabetes, seizures, arthritis, asthma, ADD, ADHD, etc): _____

_____

_____

Medication taken at school:_____

Medication taken at home: _____

Does your child wear glasses? yes no If yes, for: reading all the time

Other conditions/situations that may affect your child's school experience (family, behavior, social/emotional, etc):

_____

_____

Comments:_____

_____

In an emergency, I give consent for evaluation and treatment as described:

- **The administration of any first aid and/or medical treatment deemed necessary by a Registered Nurse, Licensed Practical Nurse, Licensed Nurse Practitioner, Licensed Physician, Licensed Dentist.**
- **The transfer to the closest hospital or health clinic when medically necessary and the parent/guardian cannot be reached.**
- **The administration of CPR/First Aid by trained school staff.**
- **Parent/Guardian: _____ Date: _____**
- **Reviewed: _____ _____ _____ _____**