Entry into School - Health History/Intake Form

To be completed by the student's parent/guardian upon initial enrollment into school.

The following questionnaire can be incorporated into an online health intake with suggested screen content, and as such, may automatically populate certain fields such as student name, gender, birth date, and grade as indicated in italicized, blue-font below.

[Screen 1] Dear Parents/Guardians,

Providing the following health information will assist the school nurse in providing a safe school environment for your student.

Student Name: ***Gender:***

Birth date: ____/_____/_____ ***Grade:***

Primary Physician/Healthcare Provider: *[Optional for response]*

Preferred Hospital: *[Optional for response]*

HEALTH INSURANCE - my student is covered by: *[Optional for response]*

_____Public (Medicaid/Medicare) _____Private (BCBS/Aetna, etc) _____No Insurance

Are you interested in receiving information about low-income eligible, health insurance programs in Kansas?
☐ YES ☐ NO *[Checking yes or no allows user to advance to next screen.]*

[Screen 2] **CHRONIC DISEASE ASSESSMENT**

Is the student currently under treatment for:

- **Asthma** ☐ Yes (Please provide a copy of an Asthma Action Plan to the school)
- **Allergies to** ☐ Food ☐ Insects ☐ Latex ☐ Unknown source ☐ Medication/Other

  List names of allergens:

  Any Food Intolerance or Celiac Disease? ☐ Yes – Specify:

  History or risk of Anaphylaxis: ☐ Yes: (Please provide a copy of the Emergency Allergy Plan to school)
- **Diabetes specify** ☐ Type 1 ☐ Type 2 (Please provide a copy of a Diabetes Medical Management Plan to the school)
- **Seizures** ☐ Yes (Please provide a copy of the Seizure Action Plan to the school)

  List Type and Frequency of Seizure Activity:

☐ **My student does not have any of the above conditions.** *[Checking this box or any box above allows user to advance to next screen.]*

[Screen 3] **Indicate other health conditions for your student by checking the boxes below and providing comments:**

Condition	Comments	Condition	Comments
☐ Anxiety/Emotional Concerns		☐ Head Injury Such as History of Concussions	
☐ Arthritis		☐ Headaches/Frequent or Migraine	
☐ Attention Deficit/ Hyperactivity Disorder		☐ Hearing Concerns or Frequent Ear Infections or Deafness – Indicate if Wears Hearing Aid or Cochlear Implant	
☐ Autism		☐ Heart problems or Blood Pressure Concerns	
☐ Behavioral Concerns		☐ Hospitalizations and Surgeries	
☐ Breathing Problem or Tracheotomy or Requires Oxygen		☐ Intellectual Disability	
☐ Developmental Concerns		☐ Lead Poisoning	
☐ Bladder Problem or Kidney Disease		☐ Muscle Problems/ Mobility or Physical Activity Restrictions	
☐ Bleeding Problem or Frequent Nosebleeds		☐ Scoliosis	
☐ Bowel Problem or Frequent Stomachaches or Constipation or Indigestion or Feeding Tube		☐ Sickle Cell Disease	
☐ Cerebral Palsy		☐ Social Concerns (recent change in family such as divorce, death of family member)	
☐ Cystic Fibrosis		☐ Speech concerns	
☐ Dental Problems		☐ Spinal Injury or Spina Bifida	
☐ Depression, Self-harm, or Suicide Concerns		☐ Underweight or Overweight	
☐ Eating Disorder		☐ Vision Deficits/Wears Glasses or Contacts/Color/ Low Vision or Blindness	
☐ Feeding or Swallowing Concern		☐ Other Condition: (List)	

☐ **My student does not have any of the above conditions.** *[Checking this box or any box above allows user to advance to next screen.]*

[Screen4] **Does your student take any medications routinely at home or at school?** ☐ Yes ☐ No

If Yes, complete the information below each medication.

Name of Medication	Time(s) Given	Will it be taken at school?*	Purpose of Medication
		☐ YES ☐ NO	
		☐ YES ☐ NO	
		☐ YES ☐ NO	
		☐ YES ☐ NO	

***Medications given at school require a medication form signed by the healthcare provider and parent/guardian.**