Student Health Intake Form – Weight imbalance

Note: Parents are to provide a physician's medical management plan to the school annually. The medical orders, along with the health intake form below, assist the school nurse in developing an Individual Healthcare Plan for the student.

Student Name: _____ **DOB:** _____/_____/_____ **Grade:**_____

Parent/Guardian 1: _____ Contact Information: _____

Parent/Guardian 2: _____ Contact Information: _____

Name of student's physician: _____

Phone number: _____

Health insurance: Private KanCare/Kansas Medicaid Uninsured

Does student have an IEP? ☐ Yes ☐ No **Current 504 plan?** ☐ Yes ☐ No

Mode of transportation to and from school? _____

Does student participate in before or after school activities? ☐ Yes ☐ No

Does student participate in school PE/sports? ☐ Yes ☐ No

If no school PE/sports participation, are there any medical accommodations or exceptions (written by a health care provider) to student's ability to participate?

☐ No ☐ Yes If yes, explain: _____

_____

Describe any outside of school physical activities:_____

_____

Does student mention issues or concerns about their weight or health? ☐ Yes ☐ No

If yes, explain: _____

Do you have any concerns about your student's weight or health? ☐ Yes ☐ No

If yes, explain: _____

Have these concerns been addressed by student's health care provider? ☐ Yes ☐ No

If yes, explain: _____

Does student have family, peer, or community support systems? ☐ Yes ☐ No

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Check the box next to any conditions that your student has been diagnosed with or that are areas of concern. For any conditions marked as a concern under psychosocial history, please also give a brief description.

Student Medical History

☐ **Type 1 Diabetes** ☐ **Type 2 Diabetes**

Has healthcare provider completed a diabetes management plan? ☐ Yes ☐ No

If yes, has a copy of diabetes management plan been given to school nurse? ☐ Yes ☐ No

Has healthcare provider completed an Emergency Action Plan (EAP) for diabetes? ☐ Yes ☐ No

If yes, has a copy of EAP been given to school nurse? ☐ Yes ☐ No

☐ **Hypertension (elevated blood pressure)**

☐ **Asthma**

Has healthcare provider completed an Asthma Action Plan? ☐ Yes ☐ No

If yes, has a copy of Asthma Action Plan been given to school nurse? ☐ Yes ☐ No

Has healthcare provider completed an EAP for asthma? ☐ Yes ☐ No

If yes, has a copy of EAP been given to school nurse? ☐ Yes ☐ No

☐ **Shortness of breath/breathing difficulties with activity**

☐ **Thyroid problem**

☐ **Heavy or irregular menstrual cycle**

☐ **Acanthosis nigricans –** areas of dark, velvety discoloration in body folds and creases, e.g., back of neck

☐ **Weight changes**

Were weight changes:
☐ Before puberty
☐ After puberty
☐ Other:

Student Psychosocial History

☐ **Being Bullied**

☐ **Low self-esteem**

☐ **Depression**

☐ **Thoughts of suicide**

☐ **Limited family resources** (i.e. housing, healthcare, adequate nutrition, child care)

☐ **Food insecurity**

Medications: List all medications student takes on a regular basis. Include over the counter medications (e.g., Tylenol, multivitamins) and medications prescribed by a health care provider.

Name of medication	Reason for medication

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Check the box next to any conditions that your student has been diagnosed with or that are areas of concern.

Student Sleep Patterns:

Average hours of sleep per night: _____

☐ Nighttime awakening/restlessness/snoring/apnea

☐ Difficulty waking in the morning ☐ Daytime sleepiness or napping

Student Orthopedic Pain:

Pain in: ☐ Groin ☐ Hip ☐ Thigh

☐ Knee ☐ Leg ☐ Feet

☐ Other: _____

☐ Limping without known injury

Student Other Symptom Complaints:

☐ Frequent headaches (describe**):** _____

☐ Headache worse when lying down ☐ Blurred vision

☐ Odor complaints ☐ Loss of bowel or bladder control ☐ Skin or wound problems

☐ Frequency of complaints:

Student Academic/Social Concerns:

☐ Low concentration

☐ Poor school performance

☐ School absences (missed more than five days in the last three months)

☐ Other: _____

Parent/Guardian Signature: _____ **Date:** _____

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