Salida School District R-32-J
Health Appraisal Form

Student's Name:_____ Grade:_____

Chronic Health Conditions

Condition	Yes	Comments	Condition	Yes	Comments
Allergies (Describe):			Diabetes		
Allergy: Bee			Dental		
Asthma			Developmental		
ADHD			Head or Spinal Cord		
Behavioral			Hearing Concerns		
Bladder or Kidney			Heart		
Bleeding			Muscle		
Bowel			Seizures		
Cerebral Palsy			Vision		
Cystic Fibrosis			Other:		

Please list any hospitalizations and/or surgeries your student has had:_____
_____

Describe any other important health-related information about your child (for example: feeding tube, oxygen, hearing aide, glasses, etc):_____
_____

List all prescription, over-the-counter, and herbal medications your child takes regularly:_____
_____

* Children who will be taking medications at school need to have written permission from a doctor and guardian on file. See the school office or nurse for a medication permission form.

Health Providers:

	Name	Phone	Date of Last Appointment
Doctor			
Dentist			
Specialist			

Child's Health Insurance: _____None _____Medicaid _____CHP+ _____Privately Purchased/Commercial/Employer Sponsored

Treatment of Minor Injuries & Illnesses

I give permission for my child,_____, to receive first aid and/or assessment for illness as needed while at school by Salida School District staff that are trained in first aid. I understand that health information may need to be shared with staff and my child's health care provider as needed for my child's safety and protection while at school.

_____ _____
Parent/Guardian Signature Date

I, the parent/guardian of_____ for whom I am legally responsible, give Salida School District consent to give or receive immunization records from_____(medical office/agency)

Parent/Guardian Signature:_____ Date:_____

Please contact the school nurse directly if you would like to discuss any of the above information that you feel is confidential.

Missy Tanner RN, Longfellow: 530-5264 Cari Beasley RN, SMS and SHS: 530-5408