ARIZONA ARTS ACADEMY

STUDENT HEALTH RECORD

Student Name (printed): _____ Date of Birth: _____

Parent/Guardian Name (printed): _____ Contact Number: _____

The school requires a doctor's order for all prescription medications, including some over-the-counter medications which need to be administered during the school year. If it is necessary for your child to receive medication at school, please note these key points. 1. The medication must be ordered for your child by a primary care physician licensed to practice in Arizona, 2. All medications (including inhalers) need to be provided in the original prescription bottle/box with a pharmacy label that includes the camper's name, name of medication, amount to be given, and name of the prescribing physician.

A. ☐ My child **DOES NOT** have any health concerns or conditions. Review all sections before checking. If nothing else applies, skip to section E for signature.

B. **Life-Threatening Conditions** (check all appropriate boxes below):

☐ My child has the following life-threatening health condition(s):

☐ **Life-threatening allergy with Epi-Pen** (epinephrine) prescribed

List the life-threatening allergens: _____

☐ **Asthma with rescue inhaler** needed at school

☐ **Diabetes:** ☐ Type 1 OR ☐ Type 2

☐ **Seizure disorder** Type: _____ Rescue medication prescribed: ☐ Yes ☐ No

☐ **Other serious health condition(s)** (e.g. heart or lung conditions, blood disorders, cancer, transplant, etc.)

Describe: _____

C. **Other Health Conditions** (check appropriate boxes below):

☐ Other allergies (medicine, bees, food, etc.): _____

☐ Gastrointestinal conditions (Celiac, IBS, encopresis, etc.): _____

☐ Neurological conditions (ADHD, Autism, TBI, migraines, etc.): _____

☐ Vision or Hearing concerns: _____

☐ Mental or Behavioral health concerns: _____

☐ Other health concerns: _____

D. **Medications:** Includes prescription, supplements, and over the counter medications

Does your child need to take medication daily or as needed at school? ☐ Yes ☐ No

If yes, please list: _____

E. Signature:

I understand that the information provided will be shared with appropriate school staff who need to know in order to provide for the health and safety of my student. I understand the nurse may communicate with my child's healthcare provider for any questions or clarifications to the medical order, medical diagnosis, or the medical plan of care.

_____

Parent/Guardian Name (signature) Date

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