OSCAR: Child Health/Special Information
(Please complete one form for each child)

Student's Name _____

Student's School _____

Parent's Name _____

Please provide the health information requested below:
_____ **No**, my child **DOES NOT** have a medical/health condition (please sign below and return).
_____ **Yes**, my child **DOES** have a medical/health concern (please complete form).
_____ **Yes**, my child does have Special Needs, a disabling condition, an IEP, or a 504 Plan for which your child may need accommodation (please complete form)

DIABETES **YES** _____ **NO** _____

ASTHMA **YES** _____ **NO** _____

ALLERGIES **YES** _____ **NO** _____

1. What causes an allergic reaction: _____
2. What are the symptoms of the reaction: _____
3. Action to taken at school in the event of a reaction
   Medication (list) _____
   Call parent (provide #'s) _____
   Call EMS (911) and parent (applies for all Epi-pen use) _____

SEIZURES **YES** _____ **NO** _____

1. Type of seizure _____
2. Date of last seizure _____
3. Average duration of seizure _____
4. Action to be taken in event of seizure _____
5. Medications (list) _____

HEART CONDITION **YES** _____ **NO** _____

1. Describe the problem _____
2. Describe any activity restriction _____
3. Medications (list) _____

SPECIAL DIET **YES** _____ **NO** _____
Please describe _____

SPECIAL NEEDS and OTHER HEALTH CONCERNS (Include disabling conditions, ADD/ADHD, depression, bipolar disorders, orthopedic conditions, etc. Use the reverse if necessary).

MEDICATION(S) (include medications that will need to be administered during OSCAR)
AM _____
PM _____
Full Day _____

By signing this form you give permission for the School Nurse and all other school personnel to share health information and discuss this health/special needs condition with OSCAR personnel.

_____ _____
Parent/Guardian Signature Date