

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

Student's Name _____

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