PEAK PERFORMANCE

# West Irondequoit Central School District

IRONDEQUOIT HIGH SCHOOL
260 COOPER ROAD
ROCHESTER, NEW YORK 14617-3095
Telephone: (585) 266-7351
Fax: (585) 336-2929

Dear Parents/Guardians:

A student's ability to learn is influenced by his/her health status. In an effort to ensure that learning and achievement take place and that a student's health needs are met, specific policies and procedures exist in the West Irondequoit Central School District. In order to maintain your child's health and safety at all times, individual health plans and emergency procedures are implemented in school under the direction of the school nurse, with parent and physician input.

School nursing personnel, in collaboration with building administrators and other school staff, are in a position to address the health-related needs of students with a high regard for protection of privacy and confidentiality.

Please carefully review and complete the confidential Student Health Information Update. This form requests your permission for the school nurse to inform the appropriate staff members of your child's health needs. Staff members are provided information and instruction about specific needs and procedures. Information about medications is for health office and/or emergency purposes only and is not shared with school personnel unless requested by a parent.

Please return this Confidential Student Health Information Update to the nurse's office at your child's school.

Thank you for completing this form. Please contact the school nurse if you have any questions, when you have additional information, or when the information is no longer needed or accurate.

Sincerely,

Mary Piston RN

Mary Piston, RN
IHS Health Office

# West Irondequoit Central School District

## Confidential Student Health Information Update

**(To be completed by parent/guardian)**

**Student Name**_____ **Birthdate**_____ **Sex**___ **School**_____ **Grade**___

**MEDICAL HISTORY: Please check any health condition(s) that pertains to your child.**

- ☐ Asthma
- ☐ Bladder/Kidney Problem
- ☐ Blood disorder
- ☐ Dental problems
- ☐ Diabetes
- ☐ Elevated Blood Pressure
- ☐ Emotional concern
- ☐ Fainting spells
- ☐ Fracture/Dislocation/Injury
- ☐ Headaches
- ☐ Hearing/Ear concern
- ☐ Heart problem/Murmur
- ☐ Seizures
- ☐ Vision/Eye concern
- ☐ Other: _____

**Please explain your child's specific needs for any checked areas:**_____

**ALLERGIES AND TREATMENT REQUIRED: List all specific allergens.**

Food:_____

Bees/Insects:_____

Medications:_____

Environmental/Other:_____

***Are these allergies Life Threatening?***_____

Usual treatment:_____

**MEDICATIONS: Please list any prescription or non prescription medication taken on a regular basis. Information about medications is included in the student's cumulative health record which is kept on file in the Health Office.**

At Home:_____

At School:_____

***Please indicate below, which School Personnel you would like to be aware of your child's medications.***

*All medications administered at school require written parental consent and a physician's order. Please obtain a current medication form from the school nurse if/when your child needs medication in school. All medication will be kept in the School Health Office for administration by the nurse. All students who self carry medication must also submit a "Parent and Prescriber's Request For Student Self Medication" to be kept on file in the School Health Office.*

**PERMISSION: <u>Please read the following three areas and include your signature as appropriate.</u>**

*<u>I give my permission</u> for the School Nurse to inform the appropriate Building Administrators, Faculty, Special Services, and Emergency Medical Services of my child's health information and needs.*

**PARENT/GUARDIAN SIGNATURE**_____ **DATE**_____

*Please specify below which additional School Personnel should be informed and instructed about your child's health needs.*

☐ Teacher Assistant ☐ Bus Driver ☐ Cafeteria ☐ Lunch Monitor ☐ Coach ☐ Trainer Other_____

*<u>I do not give permission</u> for my child's health information to be disclosed to School Personnel.*

**PARENT/GUARDIAN SIGNATURE**_____ **DATE**_____

*I have read and reviewed the Confidential Student Health Information Update form and do not have any information to report at this time.*

**PARENT/GUARDIAN SIGNATURE**_____ **DATE**_____

Confidential Health Form Effective: September through June of current school year