Van Alstyne ISD

Health Information Sheet

2018-2019 *Health Form*

Has there been ANY medical changes with your child from last school year to this current school year? ☐ Yes ☐ No

First / Prime Nombre	Middle/Segundo Nombre	Last / Apelido	Generation/Ge Neracion

Campus	Grade	Date of Birth	Gender	Physical Address	City	State	Zip
						TX	

Parent/Guardian Information

1. Parent/Guardian (Student Resides with this Parent)

Parent/Guardian Name (First and Last)	Relation to Student	
Cell Phone	**Home Phone**	**Work Phone**
Primary Parent/Guardian e-mail address		

2. Parent/Guardian

Parent/Guardian Name (First and Last)	Relation to Student		
Cell Phone	**Home Phone**	**Work Phone**	
Mailing Address	**City**	**State** TX	**Zip**

Doctor's Name ______________________

Doctor's Phone Number ______________________

Dentist's Name ______________________

Dentist's Phone Number ______________________

Does your child wear eye-glasses? ☐ Yes ☐ No

Does your child wear contacts? ☐ Yes ☐ No

Does your child have any Medical Conditions or have Allergic Reactions to any of the following? Please select any applicable Medical Conditions or Allergies for your child.

MEDICAL CONDITIONS

☐ ADD ☐ Cancer ☐ Headaches/Migraines

☐ ADHD ☐ Diabetes ☐ Hearing Impairment

☐ Asthma ☐ Epilepsy ☐ Heart Condition

☐ Other ______________________

ALLERGIES

☐ Ants ☐ Bee Stings ☐ Medication ☐ Nuts

☐ Food (please list) ______________________

☐ Other ______________________

Does your student have an EPI Pen prescribed by the Doctor? ☐ **Yes** ☐ **No**

May we provide your child's teacher with the information provided to us? ☐ Yes ☐ No

MEDICATIONS at School

Forms can be found on district site at www.vanalstyneisd.org.

For the campus nurse to be allowed to administer any prescription medication; parents are required to have the appropriate form completed by a licensed physician. All over-the-counter medications must have appropriate form filled out by a parent prior to medication being brought to school and given by nurse. Please see the district site for the form located in "Health Services".

MEDICATIONS at Home

The state of Texas requires various screenings to be done during your child's school years. For example: Vision & Hearing / Visión y audición (Pk, K, 1, 3, 5, 7 & 9); Scoliosis/ Escoliosis (6th & 9th); Acanthosis Nigrican / Acantosis Nigricans (3rd, 5th & 7th). When time allows, Vision & Hearing screenings may be done yearly. Do you give your permission for the nursing staff to do the above named screenings on your student? ☐ **Yes** ☐ **No**

Parent/Guardian Signature ______________________ Date __________