

# Bettendorf Community Schools Student Health Registration • School Year: \_\_\_\_\_

**Student's Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Grade:** \_\_\_\_\_ **Gender:** \_\_\_\_\_

*When child is ill or injured, please list which parent/guardian the school should notify first. Please list in preferred order of contact.*

#1) Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Cell#: \_\_\_\_\_ Work#: \_\_\_\_\_

#2) Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Cell#: \_\_\_\_\_ Work#: \_\_\_\_\_

*In case parent can't be reached, please contact the individual below: This person has agreed to assume this responsibility and is local.*

#3) Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Cell#: \_\_\_\_\_ Work#: \_\_\_\_\_

Child's Doctor: \_\_\_\_\_ Phone #: \_\_\_\_\_ Preferred Hospital: \_\_\_\_\_

Child's Dentist: \_\_\_\_\_ Phone #: \_\_\_\_\_ Orthodontist: \_\_\_\_\_

Type of Health Insurance:  Private  Title 19/Medicaid  Hawk-I  No Health Insurance  Other: \_\_\_\_\_

**HEALTH CONCERNS** Mark the box  if your child has a history of the following conditions. Mark additional information as needed.  
**Additional forms may need to be completed by your physician (marked with \*). Forms available on school website under Health Services.**

**Asthma or Reactive Airway Disease**  
 •Triggers →  Exercise  Colds/Allergies  Animals  Smoke  Weather  Food  Dust/Air  Other: \_\_\_\_\_  
 •Will the inhaler ever be needed at school?  No  Yes → **Asthma Action Plan\***  
 •Will the student carry their own inhaler?  No  Yes → **Authorization to Carry/Self-Administer\* (BMS and BHS ONLY, Elementary Case by Case basis)**

**Diabetes**  Type 1  Type 2  
 •Does the student use insulin?  No  Yes → **Diabetic Medical Management Plan\***  
 -Does the student use a pen or a pump?  Pen  Pump  
 •Does the student have glucagon?  No  Yes →  At school →  Office  Backpack  Locker

**Seizure Disorder → Seizure Action Plan\***  
 •Does the student have rescue meds?  No  Yes →  At school →  Office  Backpack  Locker

**Allergies [Food, Insect, Seasonal, Medication]**  
 •Is the student at risk for anaphylaxis at school?  No  Yes → **Allergy & Anaphylaxis Emergency Plan\***  
 •Will the student need a lunch accommodation?  No  Yes → **Diet Modification Form\***  
 •Does the student have an EpiPen?  No  Yes →  At school →  Office  Backpack  Locker  
 •List allergies below: **If at school → Authorization to Carry/Self-Administer (BMS and BHS ONLY)\***  
 Food(s) →  Peanut  Tree Nut  Eggs  Milk  Fish/shellfish  Soybean  Gluten  Other: \_\_\_\_\_  
 Insect stings  Seasonal allergies  Medication(s): \_\_\_\_\_  Other: \_\_\_\_\_

Heart Condition/Murmur/Disease/Surgery: \_\_\_\_\_  
 Activity Restrictions (ongoing) → **Doctor's note required for explanation\*:** \_\_\_\_\_  
 ADD / ADHD  Emotional and/or Behavioral Diagnoses →  Anxiety  Depression  Other: \_\_\_\_\_  
 Requires medication (list in chart below)  
 Headaches / Migraines: \_\_\_\_\_  
 Bowel/Bladder Concerns or Incontinence: \_\_\_\_\_  
 Assistive Equipment →  Glasses / Contacts  Hearing Aids  Wheelchair  Other: \_\_\_\_\_  
 History of Concussion / Head Injury: \_\_\_\_\_  
 Other medical history or current medical/developmental concerns that could affect child's education (use back if necessary): \_\_\_\_\_

**MEDICATIONS** List ALL medications taken regularly at home or at school. Please specify frequency and reason for use. Use back if necessary.

Medication:	Dose:	Time(s) Taken:	Frequency:	School / Home	Reason for use:

**BHS and BMS ONLY: I give permission to the school to administer over-the-counter medications:**  Acetaminophen every 4 hours  Ibuprofen every 6 hours

**I do NOT give permission to the school to administer any medications the school has available.**  
 I understand that any medication sent from home to be taken at school needs to be in the original labeled container and a Medication Authorization Form must be completed in order for it to be given. I understand that students may not carry any medications. I give permission to the school to contact my child's doctor/dentist to confirm appointments and authorize medications/plans of care as necessary. If an emergency should arise, I understand it is my responsibility to update any of the above information as needed. I understand this information is confidential but may be shared with appropriate school personnel when necessary for the child's safety or education.

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_