National Jewish Health®
Morgridge Academy

Morgridge Academy
Health Care Form
303-398-1103

Name of Child: _____
First Middle Last

☐ Male ☐ Female DOB: _____/_____/_____ Grade_____

Parent/Guardian Name: _____
First Last

Home: (_____) _____-_____ Cell: (_____) _____-_____ Work: (_____) _____-_____

Names of others in household_____

Doctor's Name_____ Dentist Name_____
Is your student covered by health insurance? ☐Yes ☐ No
Approximate date of last medical visit (include sports physical, if applicable) _____

Medications

1. List any medications and dose taken regularly _____
_____

2. Do any medicines need to be taken at school? List _____

Medical History/Conditions

1. List any serious illnesses, accidents, hospitalizations or surgery (include age) _____
_____

2. Please list any medical concern(s) that your student has **now** or had in the **past**:

Condition	Now	Past	Condition	Now	Past
Asthma or Reactive Airway Disease			Seizures type_____		
Attention Deficit Disorder (ADD or ADHD)			Skin Conditions		
Bronchitis/Pneumonia			Speech Problems		
Chickenpox			Stomach Problems		
Diabetes			Tooth Disease		
Frequent headaches (≥ 2 per week) or diagnosed migraines			**Other (Circle or list)** (Examples: heart, blood disorder, cancer, uncorrectable vision, etc)		
Mental Health Concerns					
Emotional or behavioral concern MD/Counselor Name:_____					
Head Injury			**ALLERGIES: (PLEASE LIST)** e.g. medication, food, insect bites. List allergies and required care:		
Hearing Loss/Frequent Ear Infections/Tubes in Ears (Circle)					
Heart Problems					
Neurological					
Nosebleeds					
Orthopedic/Bone Muscle Problems					

EXPLAIN ANY YES ANSWERS OR DESCRIBE ANY NEW HEALTH INFORMAION ON THE BACK

Prenatal History

Length of Pregnancy: _____Full term? Or Premature Birth? Birth Weight: _____
Complications during pregnancy? _____
Substance use during pregnancy: ☐ Alcohol ☐ Smoking ☐ Medications ☐ Recreational Drugs
Complications during birth (mom or baby)? _____
Age of mother at birth: _____ Age of father at birth _____

Early Infancy Developmental History Indicate age when student:

Sat _____ Crawled _____ Walked _____ Talked _____ Toilet Trained_____
Additional Comments/Concerns:

Miscellaneous Health Information

Does your student have a health condition that impacts his educational success, requires special equipment, therapy, or assistance? If yes, please describe: _____
Does your child wear glasses or contacts? ☐ YES ☐ NO Date of last eye exam: _____
Does your student have a 504 Plan? ☐ YES ☐ NO
Does the student have a family history of drug/alcohol substance abuse? ☐ YES ☐ NO
Does the student have a family history of learning disabilities? ☐ YES ☐ NO

Additional Information/Health Concerns of Parent

Permission for Health Advisory/Need to Know

School nurses develop a Student Health Advisory List each school year. All information is considered confidential and is shared only on a need-to-know basis.

I give permission to inform teachers and necessary staff about my child's identified health concerns. This permission shall be continuously in effect unless terminated by written notice from myself to the school in which my student is enrolled.

HEALTH CONDITION(S)

(PLEASE CIRCLE): ASTHMA, DIABETES, ADHD, OR OTHER (PLEASE LIST):

_____

Date _____ Relationship to Student_____

Signature_____ Print Name _____