Colorado Springs SCHOOL DISTRICT 11
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HEALTH INFORMATION FORM
Colorado Springs School District 11
Department of Special Education/SCHOOL NURSING

Confidential Information
Will be shared with appropriate school staff

Name_____**School:**_____**Grade:**_____**Date of Birth:**_____

Does your child have any of the following health problems? Yes / No If yes, please circle and comment below:

Autism	Bowel/Bladder	Glasses/Contacts	Seizures
Autoimmune problems	Cancer	Hay Fever	Sleep Disorder
ADD/ADHD	Diabetes	Head Injury/Concussion	Stomach
Asthma	Eating Disorder	Hearing Impaired	Vision Concerns
Blood disease	Emotional Concerns	Heart Condition	
Bone/Joint	Genetic/Congenital Abn.	Migraines	

Comments:_____

_____

_____

Other Concerns? Please describe:_____

Does your child have any significant allergies that school personnel should know about? Yes / No If yes, please list allergy and symptoms of allergic reaction:_____

How is it treated?_____

*** PLEASE NOTE:** ***If your child has a food allergy please contact the Kitchen Manager at your child's school***

Medications: Does your child take medication? Yes / No If yes, what is it for?_____

List name of medication(s) and doseage_____

Will it be given at school? Yes / No If yes, what time?_____ *

****requires completion of D11 blue medication form by parent and physician for ALL medications given at school***

Activity Restricitons: Has your child's doctor placed any current restrictions on your child's physical activities? Yes / No If yes, please describe_____*

please provide written documentation from your physician regarding any limits/restrictions on your child's physical activity

Doctor's Name:_____ **Phone:**_____

Dentist's Name:_____ **Phone:**_____

Health Insurance: Circle One Medicaid CHP+ None Private Insurance (list name of carrier)_____

If no insurance at this time, would you like to be contacted regarding health coverage? Yes / No

Consent for Medicaid Billing: I give consent to and authorize Colorado Springs School District 11 to release to Colorado Health Care Policy and Financing (HCPF) information related to Medicaid eligible services the District provides to the student identified above, as necessary, to apply for and recover partial Medicaid reimbursement. If at any time you would like to revoke this permission, please contact the school district Medicaid Office at 719-520-2251.

Emergency Care Permit: When a child suffers any injury or illness while in school, an immediate and continuing effort will be made to contact the parents. In case of serious injury or illness, first aid will be rendered in accordance with local school policies. If ambulance service is necessary, parents must assume financial responsibility.

If I cannot be reached by telephone in the event of an emergency involving _____
(Child's Name)

Please send my child to _____or any available medical service.
(Hospital Preferred)

_____ _____
(Today's Date) (Signature/Printed Name of Parent/Guardian)

What is your daytime phone number?_____

Revised 1-12-10