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BAIS SHOLOM STUDENT HEALTH AND WELLBEING FORM

Please print clearly, press hard.

STUDENT INFORMATION

Student's Last Name | First Name | Middle Name | Date of Birth *(Month/Day/Year)*

Student's Address

City | State | Zip Code | Home Phone

PHYSICAL HEALTH CARE SUMMARY

Allergies

- ☐ None
- ☐ Drugs *(list)* ___________________________________
- ☐ Foods *(list)* ___________________________________
- ☐ Insect stings ___________________________________
- ☐ Seasonal ___________________________________
- ☐ Other *(list)* ___________________________________

Treatment: ☐ Epi pen ☐ Medication _______________

Does the student have a have a past or present medical history of the ˙following?

☐ Asthma *(check severity and attach MAF/ Asthma Action Plan):* ☐ Intermittent ☐ Mild Persistent ☐ Moder. Persistent ☐ Severe Persistent

If persistent, check all current medication(s): ☐ Inhaled corticosteroid ☐ Other controller ☐ Quick relief med ☐ Oral steroid ☐ None

- ☐ Attention Deficit Hyperactivity Disorder
- ☐ Chronic or recurrent otitis media
- ☐ Congenital or acquired heart disorder
- ☐ Diabetes (attach MAF)
- ☐ Kidney disease
- ☐ Migraines
- ☐ Orthopedic Injury/disability
- ☐ Seizure disorder
- ☐ Tuberculosis (latent infection or disease)
- ☐ Other (specify) _________________________
- ☐ None

Explain all checked items above or on addendum

Medications *(attach MAF if in-school medication needed)*

☐ None ☐ Yes *(list below)*

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Dietary Restrictions

☐ None ☐ Yes *(list below)*

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Insurance
Name of Issuer:

Phone No.

Policy No.:

Health Care
Name of Provider | Provider License No. and State

Facility Name | National Provider identifier (NPI)

Address | City | State | Zip

Telephone | Fax

EMERGENCY CONTACT INFORMATION:

Parents Names:____

Phone number: ____________________, _____________________

Cell number:______________________, ______________________

E-mail: ____

E-mail: ____

1st Contact person:_______________________________

Relation:_____________

Phone number: ____________________

2nd Contact person:_______________________________

Relation:_____________

Phone number: ____________________

DEVELOPMENTAL AND EMOTIONAL SUMMARY

Does the student have a difficulty with one or more of the following?

- ☐ Bladder control
- ☐ Bowel control
- ☐ Developmental/learning problem
- ☐ Sleeping habits
- ☐ Particular fears
- ☐ Peer relationships
- ☐ Personality traits
- ☐ Speech, hearing, or visual impairment
- ☐ Other ______________________________
- ☐ None

Explain:

____

- ☐ Separation/divorce
- ☐ Family member with chronic disease
- ☐ Relocation
- ☐ Job change
- ☐ Change in family structure
- ☐ Death
- ☐ Counseling in past year
- ☐ In counseling now
- ☐ Other ______________________________
- ☐ None

Explain:

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CARE CONSENT FORM

I give permission to Mesivta of Postville – Bais Sholom, Inc. staff to obtain necessary emergency medical treatment for my child(ren.)
I give permission to the Bais Sholom's assigned medical provider to give the necessary medical treatment, as determined, to my child(ren).
I will retain financial responsibility for any such care so it does not become nor remain a liability for Bais Sholom, Inc. or Bais Sholom Inc.'s staff.
I have read all of the above and confirm that all the information I have provided is correct.

Date | Parent / Guardian Name | Signature

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