

Prekindergarten - 12th Grade  
**ENROLLMENT HEALTH INFORMATION**

Oklahoma City Public Schools

(To be completed by parent/guardian when student is enrolled and given to school nurse)

School \_\_\_\_\_ Social Security Number \_\_\_\_\_ Date \_\_\_\_\_  
Name of Student \_\_\_\_\_

Grade \_\_\_\_\_ Sex \_\_\_\_\_ Birthdate \_\_\_\_\_ Race \_\_\_\_\_ Language spoken in home \_\_\_\_\_  
Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
Father, Mother or Guardian \_\_\_\_\_ Business Phone \_\_\_\_\_

Number of siblings, age and sex \_\_\_\_\_

Does the student have a known medical diagnosis now? yes \_\_\_\_\_ no \_\_\_\_\_

If yes, please describe \_\_\_\_\_

Has your child ever been hospitalized? yes \_\_\_\_\_ no \_\_\_\_\_ if yes, list dates and explain \_\_\_\_\_

Does your child wear glasses? yes \_\_\_\_\_ no \_\_\_\_\_ if yes, date of last eye exam \_\_\_\_\_ Doctor's Name & Phone \_\_\_\_\_

Date of last dental exam \_\_\_\_\_ Dentist \_\_\_\_\_ Phone \_\_\_\_\_

Date of last physical exam \_\_\_\_\_ Doctor \_\_\_\_\_ Phone \_\_\_\_\_

Name of student's personal Physician \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Hospital Preference \_\_\_\_\_ Phone \_\_\_\_\_

EMSA member yes \_\_\_\_\_ no \_\_\_\_\_ Expiration Date \_\_\_\_\_

Does your child take medication regularly? yes \_\_\_\_\_ no \_\_\_\_\_ If yes, name of medication \_\_\_\_\_

Dosage \_\_\_\_\_ Frequency \_\_\_\_\_

Has your child taken medication previously? yes \_\_\_\_\_ no \_\_\_\_\_ If yes, please explain \_\_\_\_\_

Is your child receiving SSI? yes \_\_\_\_\_ no \_\_\_\_\_ Medical card (DHS) yes \_\_\_\_\_ no \_\_\_\_\_ (Medicaid #) \_\_\_\_\_

Did your child attend Day care \_\_\_\_\_ Preschools \_\_\_\_\_ Head Start \_\_\_\_\_

Is your child experiencing:	YES	NO		YES	NO
Eating problems	_____	_____	Emotional/Mental Problems	_____	_____
Sleeping problems	_____	_____	Discipline problems	_____	_____
Visual problems	_____	_____	Hyperactivity	_____	_____
Hearing problems	_____	_____	Physical problems	_____	_____

Does your child have a known medical condition which limits:  
Classroom activity \_\_\_\_\_ Physical education \_\_\_\_\_  
Competitive activity \_\_\_\_\_ **IF YES TO ANY OF THE ABOVE-PLEASE EXPLAIN**

Was your child's birth and delivery normal? \_\_\_\_\_ If no, explain: \_\_\_\_\_

Full term \_\_\_\_\_ Premature \_\_\_\_\_ Gestational weeks \_\_\_\_\_ Birth weight \_\_\_\_\_

Length of hospital stay: Mother \_\_\_\_\_ Baby \_\_\_\_\_

Age child was when: Breast/bottle weaned \_\_\_\_\_ Crawled \_\_\_\_\_ Walked across room \_\_\_\_\_

Single words \_\_\_\_\_ Combined words \_\_\_\_\_ Toilet trained \_\_\_\_\_

Does your child: Dress self \_\_\_\_\_ Wash/dry hands \_\_\_\_\_ Toilet independently \_\_\_\_\_

Catch ball \_\_\_\_\_ Ride tricycle/bicycle \_\_\_\_\_ Hop on one foot \_\_\_\_\_

Hand preference \_\_\_\_\_

Highly active \_\_\_\_\_ quiet \_\_\_\_\_ easily upset \_\_\_\_\_ interacts with others \_\_\_\_\_ follows directions \_\_\_\_\_ attends to tasks \_\_\_\_\_

turns TV loud \_\_\_\_\_ sits close to TV \_\_\_\_\_ repeatedly say "what"? \_\_\_\_\_ holds book close \_\_\_\_\_

**CHRONIC HEALTH PROBLEMS**

(Back)

Check appropriate answer

Systemic	Yes	No					
Allergic reaction	_____	_____	Cause	_____			
Cancer	_____	_____	Location	_____			
Migraine Headaches	_____	_____	Musculoskeletal	Yes	No	Eye	
Cardiovascular - Blood	_____	_____	Congenital deformity	_____	_____	Color blind	_____
Chronic bleeding disorder	_____	_____	Scoliosis	_____	_____	Lazy eye	_____
Heart defect	_____	_____	Arthritis	_____	_____	Eye disorder	_____
High blood pressure	_____	_____	Respiratory	_____	_____	Urinary	
Chronic nosebleed	_____	_____	Allergies - Hay Fever	_____	_____	Frequent urination	_____
Leukemia	_____	_____	Asthma	_____	_____	Chronic infections	_____
Gastrointestinal			Chronic Sinusitis	_____	_____		
Chronic stomachaches	_____	_____	Tuberculosis	_____	_____		
Constipation	_____	_____	Cystic fibrosis	_____	_____		
Ulcerative colitis	_____	_____	Endocrine				
Hepatitis	_____	_____	Growth abnormality	_____	_____		
Neuromuscular			Diabetes	_____	_____		
Tremors or twitching	_____	_____	Ear				
Seizures or convulsions	_____	_____	Chronic ear infections	_____	_____		
Serious Head Injury	_____	_____	Tubes in ears	_____	_____		
V.P. Shunt	_____	_____	Draining ears	_____	_____		
Cerebral Palsy	_____	_____					
Muscular Dystrophy	_____	_____					

If the answer to any of the above is yes-Please explain \_\_\_\_\_

The following information should be obtained from the parent when the student enrolls in school. The information should be updated as needed.

**ASTHMA INFORMATION CHECKLIST**

1. Medication	3. Are attacks precipitated by
Please list all medications your child takes:	Weather _____ Smoke _____ Dust exposure _____
Name of drug	Exercise _____ Mold exposure _____ Emotional stress _____
Date prescribed	Pollen exposure _____ Infection _____ Other _____
Dosage	
How often	
_____	Profile of Typical Attack:
_____	a. Signs, symptoms, and progression of attack _____
_____	_____
_____	b. How handled _____ Rest _____
Is your child allergic to any drugs? _____	c. Usual outcome _____
Is your child receiving allergy shot? _____ How Often _____	
2. Is there a pattern to your child's asthma attacks? _____	

**DIABETIC INFORMATION CHECKLIST**

Insulin: Morning \_\_\_\_\_ Evening \_\_\_\_\_

Diet: \_\_\_\_\_

Lunch Time \_\_\_\_\_ Snack Time A.M. \_\_\_\_\_ P.M. \_\_\_\_\_ Will bring Snack? Yes \_\_\_ No \_\_\_

Preferred treats for parties \_\_\_\_\_

Monitoring:

- Will require routine glucose monitoring at school: Yes \_\_\_ No \_\_\_
- Will \_\_\_ Will Not \_\_\_ require assistance with monitoring.
- Should routinely check blood glucose at \_\_\_\_\_ each day and record results.
- Should blood glucose be checked if symptoms of hypoglycemia are present? Yes \_\_\_ No \_\_\_

Hypoglycemia - Insulin Reaction:

- Signs child may exhibit are hunger \_\_\_\_\_, irritability \_\_\_\_\_, shakiness \_\_\_\_\_, sleepiness or confusion \_\_\_\_\_, sweating \_\_\_\_\_.
- Parents usual routine for treating insuling reaction \_\_\_\_\_
- Parents desire to be called when \_\_\_\_\_
- Time of day reactions most likely to occur \_\_\_\_\_

**SEIZURES INFORMATION CENTER**

Name of medication now using \_\_\_\_\_ Dosage \_\_\_\_\_ Need to be taken during school hours? Yes \_\_\_\_\_

No \_\_\_\_\_ If yes, when? \_\_\_\_\_

Seizures - Type \_\_\_\_\_ Describe the usual behavior following a seizure \_\_\_\_\_

Frequency \_\_\_\_\_

Date of last seizure \_\_\_\_\_

Describe a typical seizure \_\_\_\_\_ Time of day seizure usually occurs \_\_\_\_\_

(over)