

Day student Dorm student

Date: _____

STUDENT HEALTH RECORD

(To be completed by Parent/Guardian to ensure the most effective care possible for your child)

Student Name _____ Grade Entering _____
First Middle Initial Last

Gender M F Health Number _____ Expiry Date _____ Date of Birth ____/____/____
(Saskatchewan only) (mm-yyyy) (mm-dd-yyy)

Parent(s) Guardian _____
First Last First Last

Mother's (Guardian) Phone _____ Email _____
Home Cell Work

Father's (Guardian) Phone _____ Email _____
Home Cell Work

***Emergency Contact** _____
Name Phone (daytime school hours) email address Relationship to Student

****Day Students only**

Student's Home Address _____
Street City Province Postal Code

Student's mobile phone: _____

****DORM STUDENTS ONLY**** Please upload a copy of your Immunization Record.
 DO NOT SEND THE ORIGINAL DOCUMENT (to ensure that a complete immunization record is maintained, every Immunization administered to an individual will be documented by Public Health into the Electronic Provincial Immunization Registry, known as Panorama. Panorama is a secure electronic system used in Saskatchewan to record and manage immunization records and the health information related to immunization for all Saskatchewan residents. Immunization records may be shared with other health care professionals to provide public health services; assist with diagnosis and treatment; and to control the spread of vaccine preventable diseases. Information about Panorama is detailed in the "Protecting the Privacy of Your Immunization Record" fact sheet which can be obtained from the school nurse.)

ALLERGIES/ASTHMA (Please list allergies and location of medication if applicable)

<p>Asthma: Yes <input type="checkbox"/> No <input type="checkbox"/> Severe <input type="checkbox"/> Mild <input type="checkbox"/> <i>*If severe, please complete Emergency Protocol Plan</i></p> <p>Allergies: Yes <input type="checkbox"/> (Please Indicate) No <input type="checkbox"/></p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;"><input type="checkbox"/> Food:</td> <td style="width: 50%; border: none;"><input type="checkbox"/> Animals</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Egg</td> <td style="border: none;"><input type="checkbox"/> Dust</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Milk</td> <td style="border: none;"><input type="checkbox"/> Environmental</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Peanuts</td> <td style="border: none;"><input type="checkbox"/> Insect Stings</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Tree Nuts</td> <td style="border: none;"><input type="checkbox"/> Mold</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Other: _____</td> <td style="border: none;"><input type="checkbox"/> Medication: _____</td> </tr> </table> <p>Indicate symptoms student experienced & Medication or treatment required _____</p>	<input type="checkbox"/> Food:	<input type="checkbox"/> Animals	<input type="checkbox"/> Egg	<input type="checkbox"/> Dust	<input type="checkbox"/> Milk	<input type="checkbox"/> Environmental	<input type="checkbox"/> Peanuts	<input type="checkbox"/> Insect Stings	<input type="checkbox"/> Tree Nuts	<input type="checkbox"/> Mold	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Medication: _____	<p>Inhaler(s): Yes <input type="checkbox"/> No <input type="checkbox"/> Location of inhaler: _____</p> <p>Type(s): _____</p> <p>EIPEN: Yes <input type="checkbox"/> No <input type="checkbox"/> Expiry Date: ____/____/____ <small>Month Year</small></p> <p>**If Yes, please complete Emergency Protocol Plan**</p> <p>Indicate symptoms student experienced _____</p> <p>_____</p> <p>_____</p> <p>Epinephrine Auto Injector: Expiry Date _____</p> <p>_____</p>
<input type="checkbox"/> Food:	<input type="checkbox"/> Animals												
<input type="checkbox"/> Egg	<input type="checkbox"/> Dust												
<input type="checkbox"/> Milk	<input type="checkbox"/> Environmental												
<input type="checkbox"/> Peanuts	<input type="checkbox"/> Insect Stings												
<input type="checkbox"/> Tree Nuts	<input type="checkbox"/> Mold												
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Medication: _____												

Complete other side

**** = please complete Emergency Protocol Form**

Check yes or no, and write the year when your child was diagnosed if possible

	Yes	No	Year
ADD			
ADHD			
Bleeding Disorder **			
Bruise Easily			
Diabetes **			
Epilepsy **			
Eye Disorders			
Hearing Disorders			
Heart Problems**			
Headaches/Migraines			
Learning Disorders			

	Yes	No	Year
Mental Health			
• Anxiety			
• Depression			
• Schizophrenia			
• Phobias			
• Other			
Previous Surgeries			
Seizures**			
Stomach Problems			
Visual Disturbances			
Other Diseases			

Details of diagnosed conditions including any treatment or medical plan required in the event of an emergency

(Provide details below for any items marked "Yes")

Medication(s): Yes (please list) No

****DORM STUDENTS ONLY**** In the event of a minor illness over the counter medication may be given to a student according to the standing orders from the school's physician. Prescription medication will also be administered with an order from the student's physician.

Previous Injuries (Sprains, Strains, Fractures, Torn Muscles, Ligament Injuries, Dislocation)

Check Yes or No, and write the year when your child was diagnosed if possible

	Yes	No	Year
Abdominal (stomach)			
Chest/Ribs			
Concussion			
Face Injuries: Eye/Ear/Nose			
Hip			
Knee/Ankle/Foot			

	Yes	No	Year
Pelvis			
Shoulder/Upper Arm/Elbow			
Skull: Fracture			
Spine: Neck/Lower Back			
Upper Leg/Lower Leg			
Wrist/Hand			

Description(s) of previous injuries and indicate if the student requires treatment, medication or limited activity.

Please describe any other relevant conditions that may limit your child's full participation in activities.

(It is the College policy to contact the individuals whose names appear on this document at the earliest opportunity in the event of a serious illness or injury. In the event of an **Emergency** at school, 911 will be called to transport the student to the hospital.)

Signature _____ Relationship _____ Date _____ / _____ /20 _____
Month Day

Health forms will be collected by Luther College staff and will be accessible to the school nurse and shared with appropriate faculty and staff on a need to know basis. The Nurse may access eHR Viewer, a secure provincial (eHealth) electronic database, to retrieve medical information on a student regarding prescribed medication, laboratory or medical test results, clinical encounters with a physician or hospital, immunizations and chronic disease management. If you need further information regarding the nurse's access to your child's confidential medical history please contact the school nurse.