GEORGIA ACADEMY FOR THE BLIND
HEALTH SERVICES RECORD

STUDENT NAME_________________________________ DOB___________ MALE/FEMALE (please circle)

PARENT/GUARDIAN______________________________RELATIONSHIP____________________________
(Please print)

ADDRESS____ CITY____________________ ZIP___________

PHONE NUMBERS: ________________________ HOME ___________________________ CELL
________________________WORK

EMAIL ADDRESS: _____________________________________

WHAT IS THE BEST WAY TO REACH YOU? (Please circle) HOME/WORK/CELL/EMAIL/OTHER __________

EMERGENCY CONTACTS

NAME _______________________________________ RELATIONSHIP ____________________________

PHONE NUMBERS: ________________________HOME _________________________ CELL
________________________ WORK

WHAT IS THE BEST WAY TO REACH? (Please circle) HOME/WORK/CELL

NAME _______________________________________ RELATIONSHIP ____________________________

PHONE NUMBERS: ________________________ HOME _________________________ CELL
________________________ WORK

WHAT IS THE BEST WAY TO REACH? (Please circle) HOME/WORK/CELL

PRIMARY PHYSICIAN: _____________________________ PHONE: _____________________________
OPTHAMOLOGIST: _______________________________PHONE: _____________________________
NEUROLOGIST: _________________________________PHONE: _____________________________
OTHER: _______________________________________PHONE: ______________________________

WHO HAS PERMISSION TO PICK STUDENT UP FROM SCHOOL/CLINIC?
____
____
____

STUDENT'S NAME ______________________________________ TODAY'S DATE __________________

PERMISSION TO TREAT

I give permission for my child to be treated by the Georgia Academy for the Blind Health Services Nursing staff and consulting Physicians. Services provided include, but are not limited to the following:

- GENERAL PRIMARY NURSING CARE
- NURSING DIAGNOSIS AND TREATMENT OF ACUTE ILLNESSES
- NURSING DIAGNOSIS AND TREATMENT OF CHRONIC ILLNESSES
- REFERRALS FOR ILLNESSES NOT SUITABLE FOR DIAGNOSIS AND/OR TREATMENT BY NURSING STAFF
- BLOOD PRESSURE CHECKS
- BLOOD GLUCOSE CHECKS
- VISION, HEARING AND DENTAL SCREENINGS
- SCOLIOSIS SCREENING
- HEAD LICE SCREENING
- HEALTH EDUCATION FOR STUDENTS AND PARENTS
- NUTRITION EDUCATION
- ADMINISTRATION OF PRESCRIPTION MEDICATION AS ORDERED BY PHYSICIAN
- ADMINISTRATION OF OVER THE COUNTER MEDICATIONS, CREAMS AND OINTMENTS SUCH AS:
  IBUPORFEN, TYLENOL, MAALOX, TUSSIN DM, NON-PSEUDO SINUS, CLARITIN, MILK OF MAGNESIA, GAVISCON, LOTRIMIN, HYDROCORTISONE, ANTIBIOTIC OINTMENT.

IF FOR ANY REASON YOUR CHILD **CANNOT** TAKE ANY OF THE ABOVE MENTION PLEASE STATE WHICH MEDICATION AND THE REASON: ____
____
____

PARENT/GUARDIAN SIGNATURE: ____
DATE: ___________________________

STUDENT'S NAME ____ TODAY'S DATE ___________________

STUDENT HEALTH HISTORY

DIAGNOSIS: ____

ALLERGIES: (please list allergen, reaction, and treatment)

- FOOD ____
- MEDICATION ____
- INSECTS ____
- OTHER ____

LATEX? YES OR NO (please circle)

Please check all that apply. Past or present history.

_____AUTISM
_____CONSTIPATION/DIARRHEA
_____DIZZINESS/FAINTING
_____SEASONAL ALLERGIES
_____HEADACHE
_____ORTHOPEDIC PROBLEMS
_____BEHAVIOR/MOOD DISORDERS
_____THYROID DISORDER
_____BLOOD DISORDER
_____ HISTORY OF HEART DISASE/HIGH BLOOD PRESSURE
_____RESPIRATORY PROBLEMS (i.e., ASTHMA, TRACHE, etc.)
_____STROKE/MUSCLE WEAKNESS
_____KIDNEY PROBLEMS
_____SEIZURE DISORDER
_____REFLUX DISORDER/VOMITING
_____SKIN PROBLEMS
_____DIABETES. WHAT TYPE? ________________________
_____SHUNT. LOCATIONS? ___________________________

If yes, please provide an explanation and current treatment. If more space is needed, please attach a separate sheet of paper.

____
____
____
____

STUDENT’S NAME ______________________________________ TODAY’S DATE __________________

SELF CARE SKILLS

Please check all that apply. Past or present history.

TRAVEL

_____WALKS INDEPENDENTLY _____WALKS UNAIDED, BUT WITH DIFFICULTY

_____USES A CANE _____REQUIRES PHYSICAL SUPPORT

_____USES ORTHOPEDIC DEVICES, PLEASE LIST: ______________________________________

_____USES A WHEELCHAIR _____AIDED _____UNAIDED

EATING

_____NEEDS NO ASSISTANCE

_____NEEDS ASSISTANCE, PLEASE EXPLAIN: ____

_____SPECIAL DIET*****, PLEASE EXPLAIN: ____

*****If special diet is required, please make sure to fill out Eating and Feeding Evaluation attached.

TOILETING

_____NEEDS NO ASSISTANCE _____SCHEDULE TRAINED

_____NEEDS ASSISTANCE, PLEASE EXPLAIN: ____

COMMUNICATION

Please check all that apply. Past or present history.

____NEEDS A SIGN LANGUAGE INTERPRETER _____USES REGULAR PRINT

____USES LARGE PRINT _____BRAILLE

____VERBAL _____NON-VERBAL

Primary language the student speaks? ______________________________________

Primary language spoken at home? ____

HEARING

Please check all that apply. Past or present history.

____DEAF OR HEARING IMPAIRED (If checked, please indicate degree of hearing loss and in what ear and any assistive devices needed)

____

____

STUDENT'S NAME ____ TODAY'S DATE ___________________

VISION

Please check all that apply. Past or present history

_____CATARACTS _____MACULAR DEGENERATIONS _____DETACHED RETINA

_____GLAUCOMA _____DIABETIC RETINOPATHY _____STARGARDTS

_____CMV _____RETINITIS PIGMENTOSA _____USHERS SYNDROME

_____PREMATURITY OF RETINOPATHY

_____TRAUMA, please explain: ____

_____OTHER: ____

_____LOW VISION _____LEGALLY BLIND _____TOTALLY BLIND

_____LIGHT PERCEPTION ONLY

_____CORTICAL VISUAL IMPAIRMENT

_____WEARS GLASSES, please state if for vision or safety reason. _____________________________

_____CONTACT LENSES _____PROSTHESIS, please explain ____________________________