HEALTH INFORMATION

Must be updated annually

'Confidential information will be shared with school staff on a need to know basis'

PLEASE RETURN THIS HEALTH FORM TO YOUR CHILD'S SCHOOL NURSE

Student Name: _________________________________ Grade: ____________ School: ________________________

Date of birth: __________________________________ Age: ______________ Teacher: ________________________

Does your child currently have any of the following health concerns? (Please circle if applicable)

Dr. Diagnosed ADD/ADHD Medication:__________________	Dr. Diagnosed AUTISM SPECTRUM Medication:____________________	Dr. Diagnosed Heart Condition WITH ACTIVITY restrictions	Dr. Diagnosed Emotional Condition Diagnosis:____________________
Dr. Diagnosed ASTHMA Medication:__________________	Bowel/Bladder Issues	Hearing Loss	Migraine Headaches
	Diabetes: Type________________	Seizures: Type________________________	Head Injury
			Eating Disorder

Please describe the circled condition above in **greater** detail: ____

____

List any **other** current medical concerns: ____

Is your child currently taking any other medication not listed above? Yes / No **(Use back of this paper for additional space if needed)**

Medication/Dose/Time Taken:____

Medication/Dose/Time Taken:____

Does your child have any activity/dietary restrictions? **Yes / No** If yes, please list: ___________________________________

Does your child have any ***significant life threatening allergies*** that you feel school personnel need to know about? **Yes / No**
If yes, list allergy and reaction:____

Required Parent Information: (circle one) **I WILL** or **I WILL NOT**
be providing rescue medication such as Epinephrine for severe allergy noted above.

I understand that by NOT providing rescue medication, EMS (911) will be called if an emergency arises and agree to Emergency Care Permit listed below.

Date/Location of the last vision exam: ____

Does your child wear glasses or contacts? **Yes / No** Vision Diagnosis: ____

Has your child had a hospitalization or surgery within the last year? **Yes / No** ____

Student's Physician / Phone #:____

Emergency Care Permit: In case of serious illness or injury, 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, please send my child to (Hospital/Address) ___________________________________ or the nearest medical facility.

____

Parent/Guardian Signature **Best Contact Phone Number(s)**

❖ ***I am also giving the school health officials permission to talk our child's doctor about immunizations. This includes permission for the doctor's office to fax shot records to the school.***

Form Completed by:______________________________ **Relationship to Child:** ________________________**Date:** _____________

Last School Child attended: ____

Revised 4-10-24