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Rochester Public Schools

SCHOOL HEALTH INFORMATION FORM

STUDENT INFORMATION

Name DOB / / Gender ☐M ☐F

School Grade Parent/Guardian Name

Phone # Phone # Email

HEALTH HISTORY

Check all conditions your child currently has or has been treated for in the past

	CONDITION	EXPLAIN
☐	Diabetes	
☐	Seizures	
☐	Allergies	
☐	Asthma	
☐	Lung/Respiratory Disease	
☐	Heart/Cardiovascular Conditions	
☐	Head Injury/Concussion	
☐	Behavioral or Emotional Difficulties	
☐	Neurological Disorders	
☐	Attention Disorders (ADD, ADHD)	
☐	Mental Health Conditions (e.g., anxiety, depression)	
☐	Fainting Spells and Dizziness	
☐	Kidney/Bladder Conditions	
☐	Ear/Eyes/Nose/Sinus Problems	
☐	Muscle or Bone Conditions	
☐	Abdominal/Stomach/Digestive Problems	
☐	Migraines or Severe Headaches	
☐	Food Restrictions/Special Diet	
☐	Skin Conditions	
☐	Mobility Problems or Activity Restrictions	
☐	Learning Problems	
☐	VISION CONCERNS	Glasses/Contacts ☐Yes ☐No For: Last professional eye exam / / Results:
☐	HEARING CONCERNS	Hearing Device ☐Yes ☐No Type: ☐Right ☐Left ☐Both ears
☐	**List any other medical conditions:**	

MEDICATIONS

List all prescription, over-the-counter, and medications taken as needed (e.g., EpiPen, inhalers, pain relievers)

Medication	Dose	Frequency	Reason

Would you like to schedule a conference with the licensed school nurse to discuss a particular health concern? ☐Yes ☐No

Indicate your concern(s):

The information you provide will only be shared with school staff who require access to this information to meet your child's health and safety needs while at school. Not providing complete and accurate information may result in an incomplete health and safety plan for your child.

Parent/Guardian signature (Please print form to sign OR type first and last name)

Date / /

RPS-health-form revised 08/03/2016

FOR OFFICE USE ONLY: charted: (initial)

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