Student Health Information

Student Name: _____ Birthdate: _____ Grade: ___ School Year: _____

Dear Parent or Guardian,
We would like for your child to gain the most from their school experience. Health information is important in planning for your child's needs at school. Please complete this form and return it to the school nurse as soon as possible.

HEALTH CONCERNS

YES	NO	
☐	☐	Attention Deficit Hyper-activity/Attention Deficit Disorder (ADHD/ADD)
☐	☐	Allergies* - if yes, please list: _____
☐	☐	Has the allergy(s) been diagnosed by a Health Care Provider?
☐	☐	Medication(s) for allergy: _____
		Complete allergy action plan if appropriate
☐	☐	Asthma or other breathing problems - ***please describe:*** _____
		_____
☐	☐	Diabetes: ☐ Type 1* ☐ Type 2 ***Complete Diabetes treatment plan***
		Managed by: ☐ Diet/Activity ☐ Oral Meds ☐ Insulin injections ☐ Insulin injections
☐	☐	Seizure - Date and type of seizure: _____
		Complete Seizure Action Plan if appropriate
☐	☐	Heart Conditions. If yes, please list: _____
☐	☐	Has your child ever had a concussion or head injury?
☐	☐	Social, emotional, behavioral, and/or mental health concerns? If yes, please list: _____
		_____
☐	☐	Recent surgeries or hospitalization? If yes, please list: _____
		_____
☐	☐	Activity restrictions? If yes, please list: _____
☐	☐	Other health concerns? If yes, please list: _____
☐	☐	***EMERGENCIES*** – Does your child have a known health problem that could result in an emergency? If yes, please describe: _____
		Complete emergency action plan if appropriate

MEDICATIONS

List **ALL** medications your child takes: _____

List **ALL** medications and **DOSES** that your child needs **DURING THE SCHOOL DAY**. An authorization from the Health Care Provider is required each school year for all prescription medications: _____

_____

Please check what applies to your child

Vision

- ☐ Glasses/Contacts prescribed
- ☐ Wears glasses/contact all the time
- ☐ Wears glasses in classroom only
- ☐ No vision problems
- ☐ Request assistance obtaining glasses

Hearing

- ☐ Frequent ear infection (more than 3 in past year)
- ☐ Ear tube(s) ☐ Right ear ☐ Left ear
- ☐ Hearing loss ☐ Right ear ☐ Left ear
- ☐ Hearing aid(s) ☐ Right ear ☐ Left ear
- ☐ No hearing problem

Any other additional information that you feel would be helpful for the School Health Office to have access to:

_____

_____

_____

I attest to the information provided, and give permission for its release for confidential use in meeting my child's health and educational needs in school. I acknowledge that it is my responsibility to inform the school of any changes to the health status of this student, including health conditions, needs and/or allergies.

Parent/Guardian Signature: _____

Parent/Guardian Name (Please print): _____

Date: _____

Comments: _____

_____

_____

_____