Student Health Information

Must be Updated Yearly and Returned to your school.

Student Name____ Date of Birth___________________________

Physician/Clinic____ Clinic Phone___________________________

Dentist ____ Dentist Phone___________________________

Hospital Preference ____

To insure the health and safety of your child this information may be shared with school district staff or emergency personnel based on a need to know.

Health Concerns	**Yes**	**No**	**Medication** (Name, dosage)	**Necessary Monitoring** in School	Comments or **Describe**
Asthma/ Respiratory				Inhale r at School? y **N**	
Severe Allergies				Food **Latex** Insects	Type of reaction Date of Last reaction:
Diabetes					
Head Injury					
Seizures/ Neuroloqical					Type and date of last episode
Heart/ Blood					
Muscles/Bones/ JoinUSkin					
Bladder/Kidney					
Stomach/ Intestine/Bowels					
Immune Problems					
Emotiona/I Behavioral					
Hearing Concerns				Hearing **Aide?** Preferential seating?	
Vision Concerns				Glasses or Contacts? Reading Only?	
Growth/Nutrition Concerns					
Developmental Concerns					
Other Health Concerns	..				

If your child becomes ill or injured, the school will attempt to call the parent/guardian at home/work. If you cannot be reached, the school will attempt to call the emergency contact. In case of serious accident/illness/injury, 911 will be called if necessary.

Signature:____ Date:__________________