ISD 482

Little Falls Community Schools Health Form

Student Name: _____ Birthdate: ___/___/___ Grade: ____
(Last) (First) (MI)

Does your child have any health conditions?

- ☐ Asthma (inhaler? ☐Yes ☐No)
- ☐ Diabetes (insulin? ☐Yes ☐No)
- ☐ Seizures (emergency medication? ☐Yes ☐No)
- ☐ Other (adrenal insufficiency, blood disorders, cardiac concerns, etc): _____
  _____
- ☐ Mental health condition(s): _____
- ☐ No health concerns

Does your child have any allergies? _____

Does the allergy require an Epi-Pen? ☐Yes ☐No

Does your child take any medications daily or as needed? ☐Yes ☐No

Medication Name and Dose	Frequency	Reason for Medication

Will your child be taking any medication during the school day? ☐Yes ☐No

If Yes, please see your school nurse for appropriate medication authorization forms. This includes any over-the-counter medications as well as prescription medications.

Does your child require a special diet? ☐Yes ☐No If Yes, explain: _____

Does your child wear glasses and/or contact lenses? ☐Yes ☐No

Other health information or concerns: _____
_____
_____

Signature:_____ Date:_____
(Parent/legal guardian of student) (Today's Date)

Revised 3/2023