EASTERN CENTER FOR ARTS AND TECHNOLOGY

Health Information

Please complete this form to inform us about any **new** or **existing** health conditions that affect your students school day.

Student Name__________________________________ Date of Birth__________

Parent/Guardian________________________________ Phone_______________

Program______________ AM PM

Severe or life-threatening health conditions: **Physician's plan of care required**

CONDITION	CHECK IF YES	COMMENTS
Severe allergies/anaphylaxis		**Food**______________________________ **Insect stings**______________________________ **Latex**______________________________ **Other:** ______________________________ **Epinephrine prescribed YES NO**
Asthma		**Inhaler/nebulizer prescribed YES NO**
Diabetes		**Type 1_____** **Type 2_____**
Seizures		**Emergency medication needed at school YES NO**

Current physical health conditions:

CONDITION	CHECK IF YES	COMMENTS
Seasonal allergies		
Medication allergies		
Food intolerance		
Heart/Cardiovascular		
Headache/Migraines		
Mobility impairment		
Arthritis		
Other		

Emotional/Mental health conditions:

CONDITION	CHECK IF YES	COMMENTS
ADD/ADHD		
Anxiety		
Depression		
Eating disorder		
Other		