Student Health Information Form

Please complete the following health information for your child:

Last Name:_____ First Name: _____ M.I. _____

DOB: _____ School _____ Entering Grade _____

Family Physician: _____ Phone:_____

Family Dentist: _____ Phone:_____

Health Insurance _____

Please list any medications your child is currently taking:

_____

All medications must be brought into the health office by an adult in the original pharmacy labeled container. Students MAY NOT carry any prescription or over-the-counter medications on the bus or at schools (exceptions include EpiPens, inhalers, and insulin)

Please check all that apply to your child:

☐ ADD/ADHD ☐ ASD ☐ Anxiety ☐ Asthma ☐ Concussion ☐ Depression

☐ Diabetes ☐ Heart Condition ☐ Kidney Disease ☐ Migraines ☐ Seizure Disorder

Other Physical / Mental Health Issues: _____

Allergies *(please specify):* _____

Current IEP / 504 / Other: _____

Hearing Aides? ☐ Left ☐ Right ☐ Glasses ☐ Contact Lenses

Visually Impaired *(please specify):*

_____

I give my permission to administer *(please check box):*

☐ Benadryl ☐ Cough Drops ☐ Ibuprofen ☐ Tums ☐ Tylenol

☐ Potassium Iodide *(To Use in the event of a nuclear emergency)*

Please sign below to give permission to the School Nurse to perform this privilege:

I give permission to the school nurse to share information relevant to my child's health condition with appropriate school personnel when needed to meet my child's health and safety needs, to exchange information with my child's primary health care physician for the purposes of referral, diagnosis and treatment.

_____ _____

Parent / Guardian Signature Date