NORTH Clackamas Schools

Student Health Information

Student Name: _____ **Grade** _____

DOES YOUR CHILD HAVE:

Allergies (food, insect, environmental)	No	Yes	Specify_____
• Describe Reaction_____			Epi Pen? No_____ Yes_____
Anxiety/Depression	No	Yes	Specify_____
Anorexia/Bulimia/Obesity	No	Yes	Specify_____
Asthma	No	Yes	Inhaler? No_____ Yes_____
Blood disorder	No	Yes	Specify_____
Cancer	No	Yes	Specify_____
Diabetes	No	Yes	Specify_____
Epilepsy or seizures	No	Yes	Frequency _____
Heart condition	No	Yes	Specify _____
Kidney disease	No	Yes	Specify_____
Orthopedic/joint problems	No	Yes	Specify_____
Migraines/Headaches	No	Yes	Specify_____
Vision/Hearing issues	No	Yes	Specify_____
• Glasses/hearing aids	No	Yes	Specify_____
Serious illness/injury/surgery	No	Yes	Specify_____
Other illness/conditions	No	Yes	Specify_____

Does your child have anything that prevents them from regular participation in PE/recess?
No Yes Specify _____

Does your child take medication on a regular basis that will need to be given at school?
No Yes Specify _____

Does your child require any special medical equipment/medical/nursing procedures at school?
No Yes Specify _____

Kindergarten and 1st Grade Only
Preschool Experience: Check all environments your child has been in between ages 3-5:

Head start or Early Head Start
Center-based preschool/child care program (Name of center) _____
Home-based preschool/child care program
Early Childhood Special Education
Has not had preschool experience outside of home

Dental: Has your child had a dental screening in the last 12 months? No ___ Yes ___ Exempt from care ___

Vision: Has your child had a vision screening in the last 12 months? No ___ Yes ___ Exempt from care ___

Signature of Parent/Guardian: _____ **Date:**____/____/____