Cleveland School District
Student Health Record

School:_____
Grade:_____ Homeroom:_____

Student's Name: _____ Date of Birth: _____ Age: _____ Gender: _____

Address: _____ Home Phone: _____ Cell Phone: _____

Mother/Father/Guardian: _____ Work Phone: _____

Emergency Contact Person: _____ (relationship) _____ Phone: _____

Social Security No. _____ Medicaid No. _____ Health Ins. _____

Student's Medical History

Problem	**No**	**Yes**	**List symptoms and medicines needed…**
Allergies to medication			Name:
Allergies to foods			Name:
Allergies to insect bites or stings			Name:
Asthma			
Attention deficit/ADD/ADHD			
Birth Defect/Physical Handicap			
Bone or Joint Problems			
Seizures/Epilepsy			
Diabetes			
Emotional/Psychological			
Headaches (frequent or require medication)			
High Blood Pressure			
Heart Problems			
Nose Bleeds			
Sickle cell/ Trait			
Speech/Hearing Problems			
Stomach or Digestive Problems			
Surgery			
Vision (seeing) problems			Glasses? __Yes __ No Contacts? __ Yes __ No

Student's Doctor or Primary Care Provider: _____ Phone No. _____

Is the student taking daily medication? __ Yes __ No If yes, Name: _____ Dose: _____ Time given: _____

I give my permission for my child to participate in the Cleveland School District health program and to receive first aid care and health education from the school nurse (or from school personnel as designated by the principal). This may include basic vision, hearing, scoliosis screening, height, weight, head checks and vital sign measurements.
Parent/Guardian Signature: _____ Date: _____

I give my consent for pertinent medical information to be shared between the medical provider and the school nurse and/or school personnel who would be directly involved in my child's medical care.

Parent/Guardian Signature: _____ Date: _____