

Other Health Condition

Date: _____

*Please fill out this form and turn it in to your student's secretary. A new form must be completed every school year!

**A separate form must be filled out per health condition- only one health condition per form.

Student Name: _____ DOB: _____

School: _____ Teacher: _____

What Health Condition does your student have? (Please list below.)

Please explain your student's health condition below.

Is your student taking any medications for this health condition? (Please list below.) Yes: No:

Is your student taking any medications for another health condition? (Please list medication and health condition below.) Yes: No:

Is special care or treatment needed for your student? (Please explain below.) Yes: No:

Is there a Care Plan or Action Plan from your student's doctor on file with the school for this year? Yes: No:

Additional Comments: _____

Parent/Guardian Name (printed): _____

Other Health Condition

Date: _____

*Please fill out this form and turn it in to your student's secretary. A new form must be completed every school year!

**A separate form must be filled out per health condition- only one health condition per form.

Signature: _____