

MEYERSDALE AREA SCHOOL DISTRICT

Student Health Information

Name: _____ Birth date: _____ ☐ boy ☐ girl
Last First Middle

Student's Doctor's Name: _____ Date of last exam: _____

Student's Dentist's Name: _____ Date of last exam: _____

Does Student have Allergies? Yes ☐ No ☐ Please list: _____

Has the allergy required any emergency action in the past?

Yes ☐ No ☐

Bee Sting Allergy? Yes ☐ No ☐ Describe Reaction: _____

Difficulty breathing? Yes ☐ No ☐

Need emergency medication? Yes ☐ No ☐

Asthma? Yes ☐ No ☐ Triggered by: _____

Treatment _____

Diagnosed by Doctor: _____ Date: _____

Diabetes? Yes ☐ No ☐ Date Diagnosed: _____

Comments: _____

Epilepsy/Seizures? Yes ☐ No ☐ Describe Seizure: _____

Date of last seizure: _____

Medication: _____

Heart Medication? Yes ☐ No ☐ Describe: _____

Any restrictions: _____

Medications: _____

Bone Muscle Joint Problems? Yes ☐ No ☐ Describe: _____

Any physical restrictions: _____

Check off any of the following health concerns that pertain to your student:

Eyes: glasses

Ears: ☐ frequent infections

hearing aid:

☐ reading ☐ contacts ☐ difficulty seeing

☐ tubes

☐ right ☐ left

☐ distance ☐ crossed ☐ lazy eye

☐ hearing difficulty, explain _____

Other: ☐ nosebleeds ☐ headaches ☐ ADD/ADHD ☐ neurologic ☐ phobias ☐ blood disorder

☐ special physical care needed: _____

Daily medication at home: ☐ Yes ☐ No At school? ☐ Yes ☐ No Emergency only? ☐ Yes ☐ No

Name of medication and reason for taking: _____

List serious illness, surgery or injuries: _____

Other information or concerns: _____

If student requires medication / care at school, please ask the nurse for the necessary form.

Signature of parent or legal guardian

Date