



Request for Health Information

Must be completed annually

Date: _____

Please return the following form to your child's teacher **as soon as possible**. This information will be reviewed by the School Nurse.

School:	Grade:	Homeroom Teacher:
STUDENT NAME:	Date of Birth:	Bus #:
Parent/Guardian:	Daytime Phone (1):	
Parent/Guardian email:	Daytime Phone (2):	
Emergency Contact:	Phone:	
Current Doctor/Practice:	Phone:	
Current Medications:		
Medications needed at school?: ☐ No ☐ Yes* (list): _____ <i>(*) Medication consent form is required to be signed by the health care provider and the parent/guardian. Medication cannot be given until consents have been received. Consent form will be provided upon request.</i>		

Check the condition(s) your child has below, OR

☐ **MY CHILD HAS NO KNOWN HEALTH CONDITIONS**

(You may stop here if there are no known medical conditions. Please sign at the bottom and return form).

☐ ADD/ADHD (See Below) ☐ Allergies, Severe (See Below) ☐ Asthma (See Below) ☐ Autism ☐ Cancer/Leukemia Date Diagnosed: _____	☐ Cerebral Palsy ☐ Crohn's Disease/IBS ☐ Cystic Fibrosis ☐ Diabetes (See Below) ☐ Down Syndrome ☐ Epilepsy/Seizures (See Below) ☐ Glasses/Contacts	☐ Hearing Aid/Loss ☐ Concussion Date Diagnosed: _____ ☐ Heart Conditions Type: _____ ☐ Hemophilia/Bleeding Disorder ☐ Mental Health Diagnosis (See Below) ☐ Migraine Headaches	☐ Neuromuscular Disease ☐ Nosebleeds, frequent and/or severe ☐ Orthopedic Impairment ☐ Renal/Kidney Disease ☐ Juvenile Rheumatoid Arthritis ☐ Sickle Cell Anemia ☐ Ulcers/Gastric Reflux Other: _____
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FOR THE FOLLOWING CONDITIONS, PLEASE PROVIDE ADDITIONAL INFORMATION:

Severe Allergies Notify your School Nurse IMMEDIATELY If anaphylaxis may occur.	What is your child allergic to? ☐ Peanuts ☐ Tree Nuts ☐ Milk ☐ Eggs ☐ Insect Stings ☐ Other: _____ Is medication needed at school for allergies? ☐ No ☐ Yes* If yes, name: _____ Desired Location of Medication: ☐ Carried by student* (requires self-carry form) ☐ Health Room Date/Type Last Reaction: _____ Check the type of allergic reaction that occurs: ☐ Hives ☐ Swelling ☐ Difficulty Breathing ☐ Other: _____
Asthma	Is medication needed at school for asthma? ☐ No ☐ Yes* If yes, name: _____ Desired Location of Medication: ☐ Carried by student* (requires self-carry form) ☐ Health Room Date of last episode: _____ Check what is likely to cause an asthma flare: Triggers: ☐ Environmental ☐ Seasonal ☐ Exercise induced ☐ Upper respiratory infection ☐ Other: _____
Epilepsy/Seizures	Type: ☐ Convulsive ☐ Non-Convulsive Date of last seizure: _____ Is emergency medication needed at school? ☐ No ☐ Yes* If yes, name: _____
Diabetes	Type I ☐ Type II ☐ Diagnosis Date: _____ * Insulin by: ☐ Pump ☐ Injections CGM (i.e.: Dexcom): ☐ No ☐ Yes, Type: _____ <i>Please call to schedule Nurse Conference - Notify your school nurse immediately if newly diagnosed</i>
ADD/ADHD Mental Health	Type: ☐ ADD ☐ ADHD ☐ Anxiety ☐ Depression ☐ Other: _____ Medication(s) used for treatment: _____

Please be aware that the information you provide will be shared with staff on a need-to-know basis.

In the event of an emergency, and you cannot be reached, I give permission for the School Nurse to contact my doctor for further instructions on medications or care.

Signature of Parent/Guardian

Date