SAN LUIS COASTAL
UNIFIED SCHOOL DISTRICT
Division of Educational Services / Student Support Services

2026-2027 Confidential Student Health Information

Please answer the following questions as they pertain to your student. This information will assist school staff in planning for your child's needs and safety at school. **If your child has a severe health condition, please contact the School Nurse immediately through your School Secretary.**

Student Name: _____ Date of Birth: _____

Parent Name: _____ Phone: _____

Grade: ☐ Preschool ☐ TK/Kinder ☐ New Student Grade: _____

☐ My child has **NO** Health Conditions Parent Signature: _____ Date: _____

Asthma: ☐ Severe ☐ Mild Triggers: _____

Medications: _____

Allergies: ☐ Anaphylaxis: Epi-pen ☐ Severe ☐ Mild Triggers: _____

Symptoms: _____

Treatment/medications: _____

Most recent episode: _____

Diabetes: ☐ Type 1 ☐ Type 2 ☐ insulin at school ☐ syringe/pen ☐ pump ☐ independent in care

Notes: _____

Seizures: **History:** Age of first incident: _____ Type: _____

Treatment: _____

Current seizure disorder: Type: _____ Frequency: _____

Most recent seizure: _____

Treatment/medication: _____

Medication*: Name: _____ ☐ Taken at School ☐ Taken at Home

A school medication authorization form completed by both a parent and a physician is required for ANY medication (even over the counter medication) to be taken at school (form available in office).

Wears glasses: ☐ Yes ☐ No Notes: _____

Hearing Loss/Concerns: ☐ Yes ☐ No Notes: _____

Other: Please describe any health condition not listed above that may be helpful to school staff in planning for your child's needs or providing first aid to your child, such as medication side effects, use of hearing aids, orthopedic braces, temporary cast, etc.

_____

_____

_____

Please turn over

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Sleep:

Does your child have any problems going to bed? Yes ☐ No ☐

If yes, please explain_____

Does your child seem overtired or sleepy a lot during the day? Yes ☐ No ☐

If yes, please explain_____

Does your child still take naps? Yes ☐ No ☐

If yes, please explain_____

Does your child wake up a lot at night? Yes ☐ No ☐

If yes, please explain_____

Does your child have a regular bedtime and wake time? Yes ☐ No ☐

If yes, please explain_____

Does your child snore a lot or have difficulty breathing at night? Yes ☐ No ☐

If yes, please explain_____

☐ Yes ☐ No I give permission for school personnel to discuss the health conditions/medications listed herein with the physician(s) listed on my child's Emergency Information Card.

Parent Signature **Date**

Nurse's Signature **Date**