Health School Supplement Form
Northville Public Schools/Sep

Student's Name:_____ **Birthdate:**_____

PLEASE CHECK ALL PAST/PRESENT CONDITIONS THAT PERTAIN TO YOUR CHILD:

1._____Difficult Behavior
2._____Diabetes/Hypoglemia
3.____Respiratory Difficulties
4.____Eating Difficulty
5.____Bowel Problems
6.____Urinary Problems
7.____Difficulty Swallowing
8.____Sleep Difficulties
9.____Chronic Runny Nose
10.___Heart Condition
11.____Walking/Mobility
12.____Positions Restrictions
13.____Ear Tube Placement
14.____Vision Problem
15.____Hearing Problem
16.____Over/Under Weight
17.____Kidney Condition
18.____Special Health Care Needs
i.e. oxygen, suction, etc
19.____Seizures
20.____Shunt
21.____Rashes
22.____Bruise Easily
23.____Chicken pox
24.____Bruise Easily
25.____Allergies
26.____Asthma

Please comment on all checked items (attach copies of medical reports on primary problems) with dates, signs, symptoms and history:

Item# ___:_____

____:_____

____:_____

____:_____

H**ospital/Surgery/Medical Emergencies:**

1._____

2._____

3._____

Medications: List all regularly given medications (including prescribed and over the counter):

Name of Medication	**Condition for Which Prescribed**	**Dose**	**Time**
1.			
2.			
3.			

May we contact your doctor regarding your child's health? _____yes _____no

Signature of Parent/Guardian/Caretaker:_____ **Date:**_____