



Student Health Information Form

Name: _____ Birthdate: ____/____/____ Sex: M F Grade: _____

Guardian Name: _____ Primary Phone: _____ Alternative Phone: _____

Email: _____ Case Manager (if applicable): _____

School: *Futures/CHOICE/Connections*

Area Learning Center

Transition 2 Success

HEALTH CONDITIONS [Check any of the following health condition(s) your child has]

<input type="checkbox"/> ADD <input type="checkbox"/> ADHD <input type="checkbox"/> Medication at home: _____ <input type="checkbox"/> Medication at school: _____	<input type="checkbox"/> Allergies: List: _____ <input type="checkbox"/> Medication at home: _____ <input type="checkbox"/> Medication at school: _____ Anaphylactic (life threatening) Reaction <input type="checkbox"/> Yes <input type="checkbox"/> No Epi-Pen <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Asthma <i>Triggers:</i> <input type="checkbox"/> Exercise <input type="checkbox"/> Allergies <input type="checkbox"/> Colds <input type="checkbox"/> Other: <input type="checkbox"/> My child has an Asthma Action Plan <input type="checkbox"/> My child has used asthma medications in the last 2 years. <input type="checkbox"/> Medication at home _____ <input type="checkbox"/> Medication at school _____ Last Episode _____ Last Hospitalization for Asthma _____	<input type="checkbox"/> Mental Health concerns/diagnosis: Describe: _____ Medication: _____
<input type="checkbox"/> Headaches-Frequent/severe <input type="checkbox"/> Migraine <input type="checkbox"/> Medication at school List: _____	<input type="checkbox"/> Seizures/Convulsions Type: _____ Medication: _____ Last known: _____
<input type="checkbox"/> Bone or joint concern	<input type="checkbox"/> Dental/Orthodontic concerns
<input type="checkbox"/> Diabetes Medication required <input type="checkbox"/> Yes <input type="checkbox"/> No Type: _____	<input type="checkbox"/> Ear/Hearing concerns Hearing aid <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> left ear <input type="checkbox"/> right ear <input type="checkbox"/> both
<input type="checkbox"/> Food restrictions/Special diet	<input type="checkbox"/> Heart/cardiovascular Conditions
<input type="checkbox"/> Frequent/severe Kidney/Bladder conditions	<input type="checkbox"/> Learning concerns
<input type="checkbox"/> Lung/Breathing concerns	<input type="checkbox"/> Pain/Discomfort--frequent/severe
<input type="checkbox"/> Permanent or long-term disability	<input type="checkbox"/> Serious injury Describe: _____
<input type="checkbox"/> Skin Concerns	<input type="checkbox"/> Stomach or digestive concerns
<input type="checkbox"/> Weight concerns/Eating disorder	<input type="checkbox"/> Other: _____

For any conditions checked above, please specify the current status, treatment, medication, care and history.

Eye/Vision concerns? ☐ Yes ☐ No

Does child wear glasses/contacts? ☐ Yes ☐ No

Are they to be worn at school? ☐ Yes ☐ No

Date of last professional exam: ____/____/____ **Results:** _____

Does child have any activity restrictions? ☐ Yes ☐ No

Is child taking any medication not listed above? ☐ Yes ☐ No ☐ Home ☐ School **Specify:** _____

Would you like to meet with the school nurse to discuss any further concerns? ☐ Yes ☐ No
Concern: _____

The school intends to use the requested information to provide for your child's health and safety needs while at school. You may refuse to supply the requested personal information. There will be no consequence for not providing the information. It may result in an incomplete health and safety plan for your child. The information you provide will be shared only with staff in the school whose jobs require access to this information to ensure your child's safety and school success.

FOR HEALTH OFFICE USE:

Reviewed by: _____
Date Reviewed: _____
Charted by: _____
Date Charted: _____

Signature of Parent/Guardian

Date

Updated 6/22