SCHOOL HEALTH INFORMATION FORM

Name _____ Birthdate ____/____/____ Gender M F

Parent Name_____ Home Phone _____ Alt Phone _____

School _____ Grade _____ Email _____

HEALTH CONDITIONS (Check any of the following if they apply to your student)

____ ADD ____ ADHD ____ Medication at home:_____ ____ Medication at school:_____	____ Emotional/Behavior problems Describe:_____ Medication:_____
____ Allergies: List:_____ ____ Medication at home:_____ ____ Medication at school:_____ Anaphylactic (life threatening) reaction: Yes___No___ Epi-Pen: Yes___ No___	____ Headaches--frequent/severe ____ Migraines Medication at home:_____ Medication at school:_____
____ Asthma *Causes:* Exercise___ Allergies___ Colds___ Other_____ ____ My child has used asthma medications in the last 2 years ____ Medication at home:_____ ____ Medication at school:_____ Last Episode:_____ Last hospitalization for Asthma:_____	____ Seizures/Convulsions Type:_____ Last known:_____
____ Bone or joint conditions	____ Learning problems
____ Dental/Orthodontic problems	____ Lung/Breathing problems
____ Diabetes	____ Pain/Discomfort--frequent/severe
____ Ear/Hearing problems	____ Permanent or long-term disability
____ Eye/Vision problems	____ Serious Injury
____ Food restrictions/Special Diet:_____	____ Skin Conditions
____ Heart/Cardiovascular conditions	____ Stomach/Intestinal/Abdominal conditions
____ Infections--frequent/severe	____ Weight concerns/Eating Disorders
____ Kidney/Bladder conditions	____ Other

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

_____

_____

Does child wear glasses/contacts? ___Yes ___ No **Are they to be worn at school?** ___Yes ___ No

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

Does child have any activity restrictions? ___ Yes ___ No

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

Do you want to schedule a conference with the School Public Health Nurse to discuss any particular health concerns? ___ Yes ___ No

Indicate your concern: ___ Medications ___ Emergency Plan ___ Other:_____

Additional information you care to share:_____

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.

_____ _____

Signature of Parent/Guardian Date

FOR HEALTH OFFICE USE:

Reviewed by:_____

Date reviewed:_____

Charted by:_____

Date charted:_____