Health Information

Student Name _____ School _____ Grade _____

Please check all that apply ☐ No health concerns, please sign at bottom

☐ **ADD** ☐ Current Diagnosis ☐ History

☐ **ADHD** ☐ Medication Name: _____ ☐ At Home ☐ At School

Allergies ☐ Current Diagnosis ☐ History

☐ Medication Name: _____ ☐ At Home ☐ At School

☐ Seasonal Allergies ☐ Eczema ☐ Drug ☐ Bee/Wasp ☐ Tree nuts ☐ Peanuts

☐ Other nut allergies: _____

☐ Other Allergies: _____

Asthma ☐ Current Diagnosis ☐ History

☐ Medication Name: _____ ☐ At Home ☐ At School

Diabetes ☐ Type 1 ☐ Type 2 ☐ Medication Name: _____

☐ Pump ☐ Pen ☐ Syringe

Migraines ☐ Current Diagnosis ☐ History

☐ Medication Name: _____ ☐ At Home ☐ At School

Seizures ☐ Current Diagnosis ☐ History

☐ Medication Name: _____ ☐ At Home ☐ At School

☐ Generalized tonic-clonic ☐ Absence ☐ Partial ☐ Simple ☐ Complex

☐ Other not listed above: _____

☐ **Vision Concerns** ☐ **Hearing loss concerns** ☐ **Bladder Concerns** ☐ **Kidney Concerns** ☐ **Skin Concerns**

☐ Right ☐ Left ☐ Both ☐ **Heart Condition** ☐ **Joint Disease**

Specify: _____

Limitations or restrictions: _____

Other: _____

Surgeries: _____

I understand that this information is confidential and will be kept with my child's school health record. I give my permission for this information to be released, on a need to know basis, to other school staff who may be working with my child or supervising activities in which my child is involved.

_____ _____

Signature of Parent/Legal Guardian Date

I understand that if my child will be taking any daily and/or as needed medication at school a Medication Administration Authorization Form needs to be signed by a parent and if a prescription medication, the form is also signed by the physician/licensed provider. Forms are available on our website under school nurses, at our school offices, and if your clinic has developed their own form, that can be used. Inhalers/Epi-Pens may be carried by a student only if a Medication Form is on file at the school. All medication must be in the original container, and prescription medication must be hand-delivered by a parent/designated adult.

_____ _____

Signature of Parent/Guardian Date