

Health Information

Student Name _____ School _____ Grade _____

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

<input type="checkbox"/> ADD	<input type="checkbox"/> Current Diagnosis	<input type="checkbox"/> History		<input type="checkbox"/> At Home	<input type="checkbox"/> At School
<input type="checkbox"/> ADHD	<input type="checkbox"/> Medication Name: _____				
Allergies					
<input type="checkbox"/> Medication Name: _____	<input type="checkbox"/> Current Diagnosis	<input type="checkbox"/> History		<input type="checkbox"/> At Home	<input type="checkbox"/> At School
<input type="checkbox"/> Seasonal Allergies	<input type="checkbox"/> Eczema	<input type="checkbox"/> Drug	<input type="checkbox"/> Bee/Wasp	<input type="checkbox"/> Tree nuts	<input type="checkbox"/> Peanuts
<input type="checkbox"/> Other nut allergies: _____					
<input type="checkbox"/> Other Allergies: _____					
Asthma					
<input type="checkbox"/> Medication Name: _____	<input type="checkbox"/> Current Diagnosis	<input type="checkbox"/> History		<input type="checkbox"/> At Home	<input type="checkbox"/> At School
Diabetes					
<input type="checkbox"/> Pump	<input type="checkbox"/> Type 1	<input type="checkbox"/> Type 2	<input type="checkbox"/> Medication Name: _____		
	<input type="checkbox"/> Pen	<input type="checkbox"/> Syringe			
Migraines					
<input type="checkbox"/> Medication Name: _____	<input type="checkbox"/> Current Diagnosis	<input type="checkbox"/> History		<input type="checkbox"/> At Home	<input type="checkbox"/> At School
Seizures					
<input type="checkbox"/> Medication Name: _____	<input type="checkbox"/> Current Diagnosis	<input type="checkbox"/> History		<input type="checkbox"/> At Home	<input type="checkbox"/> At School
<input type="checkbox"/> Generalized tonic-clonic	<input type="checkbox"/> Absence	<input type="checkbox"/> Partial	<input type="checkbox"/> Simple	<input type="checkbox"/> Complex	
<input type="checkbox"/> Other not listed above: _____					
<input type="checkbox"/> Vision Concerns					
<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	<input type="checkbox"/> Hearing loss concerns	<input type="checkbox"/> Bladder Concerns	<input type="checkbox"/> Kidney Concerns
		<input type="checkbox"/> Heart Condition	<input type="checkbox"/> Skin Concerns		
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