# STUDENT HEALTH INFORMATION

| **Part 1** | **Parent or Guardian to Complete** | | **School Year: 20_____ - 20_____** | | | |
|---|---|---|---|---|---|---|
| Student's Name: Last | First | | Grade | Homeroom Teacher: | Sex ☐ M ☐ F | Birth date: |
| Father's Name and Daytime Phone Number: | | Mother's Name and Daytime Phone Number: | | | Home Phone Number: | |

**Part 2** **Health History** **Please check all boxes below that apply to your student.** Parents are responsible for providing the school with any medication or medical equipment that is needed to care for their child during the school day. If there are any changes to your child's health condition during the school year please inform the school nurse ASAP.

****This information may be shared by the school nurse with school staff as needed to best serve your child while at school****

| | |
|---|---|
| ☐ **My child has no known health problems** (skip to part 5) | |
| ☐ ADD/ADHD | |
| ☐ Allergies-Severe-requiring Epi-pen &/or Benadryl | ☐ Bees/Insect Sting ☐ Food (specify): _____ ☐ Other severe allergy (specify): |
| ☐ Asthma | ☐ Rescue Inhaler ☐ Nebulizer ☐ None ☐ Known triggers: |
| ☐ Autism Spectrum Disorder | |
| ☐ Blood Disorder | Specify: |
| ☐ Cancer | Type: ☐ Under Treatment ☐ In remission since: |
| ☐ Cerebral Palsy | |
| ☐ Cystic Fibrosis | |
| ☐ Diabetes | ☐Type I ☐Type II ☐ Insulin Pump ☐ Insulin by injection |
| ☐ Down's Syndrome | |
| ☐ Eating Disorder | Specify: |
| ☐ Epilepsy/Seizures | Approximate date of last seizure: |
| ☐ Migraine headaches (diagnosed by MD) | How frequent? |
| ☐ Hearing Problems | ☐Wears Hearing Aid: ☐Left ☐Right ☐Cochlear Implant: ☐Yes ☐No |
| ☐ Heart Condition | Specify: |
| ☐ Has your child had any head injury/concussion during the past year? | ☐ Yes If so, when: ☐No |
| ☐ High Blood Pressure | |
| ☐ Kidney or Bladder Problems | Specify: |
| ☐ Mental Health Condition | Specify: |
| ☐ Muscular Dystrophy | |
| ☐ Other Physical Impairment or Birth Defect | |
| ☐ Sickle Cell | |
| ☐ Skin Problems/Eczema | |
| ☐ Spina Bifida | |
| ☐ Vision Problems (severe) | |
| ☐ Other (describe) | |

**Part 3** **Medications**

Does your child take medications(s) regularly? ☐ No ☐Yes List Meds:_____

Will your child need medication(s) at school? ☐ No ☐ Yes List Meds:_____

****Medications cannot be given at school without proper documentation in place. See the medication policy in your parent handbook****

**Part 4** **Dietary and Activity Restrictions**

Does your child have any activity restrictions? ☐ Yes ☐ No If yes, please provide doctor's note for those restrictions at school.

****If your child has a life threatening food allergy or requires a modified texture diet, a diet order form will need to be completed by the doctor****

**Part 5** **Health Insurance**

Does your child have health insurance/Medicaid/Health Choice? ☐ Yes ☐ No

**Part 6** **Medical Providers**

Doctor: Phone

Specialist: Phone Specialty:

**Part 7** **Release of Information**

I give permission for the school nurse to exchange information regarding my child's medical condition(s) with the medical provider(s) listed above. ☐ Yes ☐ No

**Parent/Guardian Signature:** **Date:**

5/16kgr