## HEALTH INFORMATION

**Must be updated annually**

***'Confidential information will be shared with school staff on a need to know basis'***

# PLEASE RETURN THIS HEALTH FORM TO YOUR CHILD'S SCHOOL NURSE

Student Name: ________________________________ Grade: ___________ School: ________________________

Date of birth: _________________________________ Age: _____________ Teacher: ________________________

**Does your child currently have any of the following health concerns? (Please circle if applicable)**

| | | | |
|---|---|---|---|
| Dr. Diagnosed ADD/ADHD<br>Medication:_________________ | Dr. Diagnosed AUTISM SPECTRUM<br>Medication:___________________ | Dr. Diagnosed Heart Condition<br>WITH ACTIVITY restrictions | Dr. Diagnosed Emotional Condition<br>Diagnosis:___________________ |
| Dr. Diagnosed ASTHMA<br>Medication:_________________ | Bowel/Bladder Issues | Hearing Loss | Migraine Headaches |
| | Diabetes: Type_______________ | Seizures:<br>Type______________________ | Head Injury |
| | | | Eating Disorder |

Please describe the circled condition above in **greater** detail: ______________________________________________________

______________________________________________________________________________________________

List any **other** current medical concerns: ___________________________________________________________

**Is your child currently taking any other medication not listed above? Yes / No** **(Use back of this paper for additional space if needed)**

**Medication/Dose/Time Taken:**___________________________________________________________________________

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Does your child have any activity/dietary restrictions? **Yes / No** If yes, please list: ___________________________________

Does your child have any ***significant life threatening allergies*** that you feel school personnel need to know about? **Yes / No**
If yes, list allergy and reaction:____________________________________________________________________

***Required Parent Information***: (circle one) **I WILL** or **I WILL NOT**
be providing rescue medication such as Epinephrine for severe allergy noted above.

I understand that by NOT providing rescue medication, EMS (911) will be called if an emergency arises and agree to Emergency Care Permit listed below.

Date/Location of the last vision exam: ______________________________________________________________

Does your child wear glasses or contacts? **Yes / No** Vision Diagnosis: ____________________________________________

Has your child had a hospitalization or surgery within the last year? **Yes / No** ________________________________________

Student's Physician / Phone #:__________________________________________________________________________

**Emergency Care Permit:** In case of serious illness or injury, first aid will be rendered in accordance with local school policies. If ambulance service is necessary, parents must assume financial responsibility. If I cannot be reached by telephone in the event of an emergency, please send my child to (Hospital/Address) ________________________________ or the nearest medical facility.

______________________________________________________________________________________________

**Parent/Guardian Signature** **Best Contact Phone Number(s)**

- ***I am also giving the school health officials permission to talk our child's doctor about immunizations. This includes permission for the doctor's office to fax shot records to the school.***

**Form Completed by**:______________________________ **Relationship to Child:** ________________________**Date:** _____________

Last School Child attended: ________________________________________________________

Revised 4-14-17