

STUDENT HEALTH FORM

Student name _____ Birth date _____ Grade level _____

Physician _____ Phone (____) _____ Dentist _____ Phone (____) _____

Health conditions. *Please check all that school staff should be aware of.*

- | | |
|--|--|
| <input type="checkbox"/> Asthma. Uses inhaler <input type="checkbox"/> yes <input type="checkbox"/> no | <input type="checkbox"/> Attention deficit disorder |
| <input type="checkbox"/> Bone disease/fractures | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Physical handicap |
| <input type="checkbox"/> Ear infections (chronic/numerous) | <input type="checkbox"/> Seizure disorder |
| <input type="checkbox"/> Emotional disturbances | <input type="checkbox"/> Special dietary regimen |
| <input type="checkbox"/> Frequent headaches/migraines | <input type="checkbox"/> Surgeries |
| <input type="checkbox"/> Frequent stomach aches | <input type="checkbox"/> Throat infections (chronic/numerous) |
| <input type="checkbox"/> Glasses <input type="checkbox"/> Contact lenses | <input type="checkbox"/> Head injuries |
| <input type="checkbox"/> Digestive problems | <input type="checkbox"/> Hearing impairment. Uses hearing aid <input type="checkbox"/> yes <input type="checkbox"/> no |
| <input type="checkbox"/> Heart/blood disease | |

Allergies. List all known allergies for this student (include medications, foods, insects, environmental, etc.):

A physician has prescribed the use of an Epi-Pen for _____ allergy. yes no

Please complete this section if your child has been diagnosed with ANY of the items above.

Number of times child has been taken to an emergency room for an episode in the past 12 months:

Describe the type of symptoms your child experiences:

Is there anything that triggers the symptoms?

What usually helps if an episode occurs?

Medications child takes for this condition: Name, dose, frequency:

List any other medications this student takes on a routine basis:

Asthma: Does your child use a peak flow meter? yes no If yes, what is the child's best peak flow?

I know of no health reason(s), other than the information indicated on this form, why my child should not participate in any school activity. I authorize school personnel to obtain emergency medical care for my child in the event I cannot be reached. Transportation by ambulance is authorized is required.

Parent/legal guardian signature _____ Date _____