CONFIDENTIAL HEALTH INFORMATION

Current health information is necessary for the school to best meet the needs of the student while he or she is in the school setting. **PLEASE COMPLETE THOROUGHLY.**

Student_________________________________Teacher_________________________Grade__________Date_______________

Doctor_____________________________ Address____ Phone #________________

Medical Conditions	Past (Date/Age)	Present	Descriptions & Symptoms	Current Medication At Home	Current Medication At School Only By Physician Prescription	Action Desired At School
ALLERGIES **PLEASE "X"** Environment ☐Yes ☐No						
Food ☐Yes ☐No Epi-pen ☐Yes ☐No						
Insect Bites/ Bee Stings ☐Yes ☐No Epi-pen ☐Yes ☐No						
Medicine ☐Yes ☐No						
ASTHMA ☐Yes ☐No						
DIABETES ☐Yes ☐No						

CONVULSIVE DISORDERS *Grand Mal* ☐ Yes ☐ No *Petit Mal* ☐ Yes ☐ No *Fever Convulsions* ☐ Yes ☐ No

IF YES, DATE OF LAST EPISODE ________________________ MEDICATION REQUIRED____

ACTION DESIRED AT SCHOOL____

REGULAR, CONTINUING, LONG-TERM MEDICATION: ☐ Yes ☐ No **NAME OF MEDICATION, DOSAGE, FREQUENCY**___________________

____

If student is on continuing medication: I give my permission for the school to contact my doctor regarding medication:

____ ______________________

Signature Date

WILL STUDENT NEED MEDICATION AT SCHOOL: ☐ Yes ☐ No ***If medication is required at school, the law requires a written order from doctor and parent.***

PLEASE COMPLETE BOTH SIDES

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VISUAL IMPAIRMENT: ☐ Yes ☐ No CORRECTED BY: ☐ Glasses ☐ Contact Lens REQUIRED: ☐ School ☐ Distance ☐ Reading

HEARING LOSS: ☐ Yes ☐ No DEGREE OF IMPAIRMENT: ________________________________ Uses Hearing Aid: ☐ Yes ☐ No

EAR INFECTIONS: ☐ Yes ☐ No FREQUENCY_______________ DATE TUBES INSERTED__________ DATE TUBES REMOVED ____________

HEART DISEASE/CONDITION ☐ Yes ☐ No DATE______________ EXPLAIN____

Medication Required____ Action Desired at School____

NEUROLOGICAL DISORDERS ☐ Yes ☐ No EXPLAIN____

KIDNEY DISEASE ☐ Yes ☐ No EXPLAIN____

BONE OR JOINT DISEASE AND/OR INJURY ☐ Yes ☐ No DATE______________ EXPLAIN____

BLEEDING DISORDERS ☐ Yes ☐ No EXPLAIN____

EMOTIONAL PROBLEMS ☐ Yes ☐ No EXPLAIN____

Has your child had?

Serious Illness? ☐ Yes ☐ No DATE________________ EXPLAIN____

Serious Injury? ☐ Yes ☐ No DATE________________ EXPLAIN____

Surgery (Operations)? ☐ Yes ☐ No DATE________________ EXPLAIN____

Childhood Diseases? ☐ Yes ☐ No If yes, indicate date or age. Chickenpox______________ (Date/Age) Mumps______________ (Date/Age) Tuberculosis_________________ (Date/Age)

Other (Describe)____

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*PARENT SIGNATURE*____ *DATE*____

PLEASE COMPLETE BOTH SIDES