

**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 Medication: _____	Dr. Diagnosed AUTISM SPECTRUM Medication: _____	Dr. Diagnosed Heart Condition WITH ACTIVITY restrictions	Dr. Diagnosed Emotional Condition Diagnosis: _____
Dr. Diagnosed ASTHMA Medication: _____	Bowel/Bladder Issues	Hearing Loss	Migraine Headaches
	Diabetes: Type _____	Seizures: 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: \_\_\_\_\_