HEALTH INFORMATION FORM 2023-2024

To: Parents/Guardian

For your child to gain the most from his/her education, it is important for the school office to have a current health history.

STUDENT NAME _____ Male/Female Grade _____

FATHER/GUARDIAN _____HOME/Cell#_____ WORK#_____

MOTHER/GUARDIAN _____HOME/Cell#_____ _____ WORK#_____

EMERGENCY CONTACT _____/ _____ / _____

Name Relationship to student Phone #

DOCTOR NAME _____Phone # _____ Have you had a physical exam in the past 1 yr. __ 2 ___

DENTIST NAME _____Phone # _____ Have you had a dental exam in the past 1 yr.? _____

Do you have health insurance? Yes _____ No _____

Why type of health insurance? Employer _____ Private _____ Medicaid _____

My child has no current health concerns _____

MY CHILD MAY RECEIVE EMERGENCY CARE AND/OR FIRST AID AND/OR TRANSPORTED TO

_____ (NAME OF HOSPITAL)

I permit the school nurse to share information with the staff, as deemed appropriate by the nurse, to provide for my Child's health and safety.

PARENT / GUARDIAN SIGNATURE _____ DATE _____

My Child has the following current health concerns:

ASTHMA: _____ triggered by: _____

Medications/ Treatments _____

Give at home _____ School _____ Diagnosed by Physician at _____ years of age

ALLERGIES _____ (drugs, food, insects, pollens, etc.) please list _____

Treatment _____ Required emergency treatment _____ yes _____ No

ALLERGIC TO ANY OF THE FOLLOWING OVER THE COUNTER DRUGS:

Neosporin ____ First Aid Crème ____ Bandages ____ Peroxide ____ Alcohol _____ Others _____

ATTENTION DEFICIT DISORDER: _____ (ADD/ADHD)

Medication(s) _____ given at home _____ at school _____

Comments _____

DIABETES: _____ Insulin dependent? _____ Yes _____ No

Describe reactions _____

Comments _____

SEIZURES: _____ Date of last seizure _____ Describe seizures _____

Medication _____

Comments _____

HEADACHES: _____ Describe headaches (kind and frequency) _____

Treatment _____

OTHER MEDICATIONS: Home _____ School _____

Reason for taking _____

EYES: _____ Glasses _____ Contacts _____ Lazy Eye _____

Date of last vision exam (other than school screening) _____

EARS: _____ Frequent infections _____ tubes _____ day of placement _____

Hearing aid (Right/Left) _____ other hearing problems (explain) _____

OTHER HEALTH CONCERNS: nose bleeds _____ dental _____ skin conditions _____ heart _____ lungs _____

Bladder _____ bowels _____ orthopedic (bones) _____ neurological) brain/nervous system) _____

Blood disorder _____ blood pressure _____ eating _____ sleeping _____ menstruation _____ phobias (fears) _____

Any other specific illness, injury, problems which affect his/her school experience? _____

I verify that my child had varicella (chicken pox) disease on or about _____ / _____ /_____.