LAST NAME:

Reviewed by

Student Health Information / Concerns

Student Name: _____ **Birth Date** _____ ☐ **Male** ☐ **Female Grade**____

Parent/Guardian: _____ **Phone: Home:** _____ **Work:** _____ **Cell:** _____

Dear Parent/Guardian:
Your child's health may affect his or her learning. Health information is important in planning for your child's needs at school. Your input and involvement are important. Please complete this form and return it to school as soon as possible.

HEALTH CONCERNS: Please X and explain if your child has any of the following:

Yes	No	
☐	☐	Attention Deficit Hyper-activity Disorder/Attention Deficit Disorder (ADHD/ADD)
☐	☐	Allergies* (to what? _____)
☐	☐	Has the allergy been diagnosed by a doctor?
☐	☐	Medication for allergy: _____ ***Complete allergy action plan if appropriate***
☐	☐	Asthma or other breathing problems:
☐	☐	Has asthma been diagnosed by a Health Care Provider?
☐	☐	Hospitalization in the last year for asthma?
☐	☐	Ever hospitalized for asthma? ***Complete asthma action plan if appropriate***
☐	☐	Other breathing problem (describe): _____
☐	☐	Diabetes: ❒ Type 1* ❒ Type 2 ***Must complete diabetes emergency plan.*** Managed by: ❒ Diet/Activity ❒Oral meds ❒ Insulin injections ❒ Insulin Pump
☐	☐	Heart Conditions: _____
☐	☐	Seizures: Date & type of last seizure: _____ ****If yes must complete seizure action plan.***
☐	☐	Has your child ever had a concussion or head injury?
☐	☐	Social/emotional/behavioral/mental health concerns: _____
☐	☐	Has your child ever been the victim of bullying?
☐	☐	Recent surgeries or hospitalizations: _____
☐	☐	Activity restrictions: _____
☐	☐	Receives Special Education /IEP/504 Services
☐	☐	Other health concerns: _____

EMERGENCIES: Does your child have a known health problem that could result in an emergency? ❒ **Yes*** ❒ **No**

**** Must complete emergency action plan***

Please describe: _____

MEDICATIONS

First, list ALL medications that your child takes: _____

Now, list **ALL** medications that your child needs DURING THE SCHOOL DAY. An authorization with parent and health care provider consent is required each school year for all the following listed prescription AND over-the-counter medications:

_____

_____

Please complete and sign back of form

Vision

- ☐ Glasses/contacts prescribed
- ☐ Wears glasses/contacts all of the time
- ☐ Wears glasses in classroom only
- ☐ No vision problem
- ☐ Request assistance obtaining glasses

Hearing

- ☐ Frequent ear infections (more than 3 per year in past year)
- ☐ Has ear tube(s)
- ☐ Hearing loss ☐ right ear ☐ left ear
- ☐ Hearing aid(s) ☐ right ear ☐ left ear
- ☐ No hearing problem

HEALTH INSURANCE:

My child has health insurance: Yes No

I request assistance with health insurance: Yes No

HEALTH CARE PROVIDERS:

Does your child have a doctor or clinic where they usually go for health care? Yes No
If yes, please complete the following:

_____ _____

Primary Heath Provider **Location and Phone**

_____ _____

Dental Provider **Location and Phone**

_____ _____

Other **Location and Phone**

Hospital preference_____

I attest to the information provided and give permission for its release for confidential use in meeting my child's health and educational needs in school. I acknowledge that it is my responsibility to inform the school of any changes to the health status of this student including health conditions, needs, and/or allergies.

Parent/Guardian signature _____ **Daytime phone** _____

Print Parent/Guardian name: _____ **Date:** _____

Parent/Guardian e-mail contact: _____

Comments: _____

_____

_____

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