Student Health Information

Student Name: _____

1. Illness Record (check all that apply)

_____ Asthma

_____ Diabetes

_____ Epilepsy/Seizure

_____ Seasonal Allergies

_____Other serious illness/accident (please explain) _____

_____

2. Does your child have any special needs, problems, or fears? Please explain: _____

_____

_____

3. Are the problems serious enough to restrict child's activities? YES / NO Please Explain:

_____

_____

4. Describe, if any, special care required: _____

_____

5. List any allergies/food allergies staff should be aware of: _____

_____

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Student Health Information *continued*

6. Is your child taking prescribed medication? YES / NO If yes, for what reason? _____

_____

Is it a chronic illness? YES / NO

7. What is the name of the medication? _____

8. Are you requesting any medication to be administered at/by school? YES / NO

If you answered "YES", a completed medication authorization must be on file in student's records.

Please speak to the office for details. Office use: Med. Auth. On file YES / NO

9. Official copy of child's immunization record is required. Office use: Med. Auth. On file YES / NO

10. Official copy of child's birth certificate is required. Office use: Med. Auth. On file YES / NO

11. Health statement signed by child's doctor (included in packet) is required. Office use: Med. Auth. On file YES / NO

Parent/guardian Signature:_____Date_____