

SCHOOL HEALTH INFORMATION FORM

2019-2020

STUDENT INFORMATION

Name: _____ DOB: / / _____ Grade: _____ Gender Male Female

Parent/Guardian Name(s): _____ Phone #1: _____

Phone#2: _____ Email: _____

Emergency Contact #1 (other than parent/guardian): _____ Phone # _____

Emergency Contact #2 (other than parent/guardian): _____ Phone # _____

HEALTH HISTORY (Check all conditions your child currently has or has been treated for in the past)

	Condition	Explain
<input type="checkbox"/>	Diabetes	
<input type="checkbox"/>	Seizures	
<input type="checkbox"/>	Allergies	
<input type="checkbox"/>	Asthma	
<input type="checkbox"/>	Lung/Respiratory Disease	
<input type="checkbox"/>	Heart/Cardiovascular Disease	
<input type="checkbox"/>	Behavioral or Emotional Difficulties	
<input type="checkbox"/>	Neurological Disorders	
<input type="checkbox"/>	Attention Disorders (ADD/ADHD)	
<input type="checkbox"/>	Mental Health Conditions (e.g. anxiety, depression)	
<input type="checkbox"/>	Fainting spells and dizziness	
<input type="checkbox"/>	Kidney/Bladder Conditions	
<input type="checkbox"/>	Ear/Eyes/Nose/Sinus problems	
<input type="checkbox"/>	Muscle or Bone conditions	
<input type="checkbox"/>	Abdominal/stomach/digestive problems	
<input type="checkbox"/>	Migraine or Severe Headaches	
<input type="checkbox"/>	Food Restrictions/Special Diet	
<input type="checkbox"/>	Skin Conditions	
<input type="checkbox"/>	Mobility Problems or Activity Restrictions	
<input type="checkbox"/>	Learning Problems/Difficulties	
<input type="checkbox"/>	IEP or 504	
<input type="checkbox"/>	Head Injury/Concussion	
<input type="checkbox"/>	Skin Conditions	
<input type="checkbox"/>	VISION CONCERNS	Glasses/Contacts <input type="checkbox"/> Yes <input type="checkbox"/> No For: Last professional eye exam / / Results:
<input type="checkbox"/>	HEARING CONCERNS	Hearing Device <input type="checkbox"/> Yes <input type="checkbox"/> No Type: <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both ears
<input type="checkbox"/>	List any other medical conditions:	

Family Doctor: _____ Clinic: _____

MEDICATIONS List all prescription, over-the-counter and medications taken as needed (Epi-Pen, inhalers, pain relievers)

Medication	Dose	Frequency/Time	Reason	Needed at school?

Would you like to schedule a conference with the licensed school nurse to discuss a particular health concern? Yes No

Indicate your concern(s): _____

