SCHOOL HEALTH INFORMATION FORM

2020-2021

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

(Health Office Use Only)

-