SCHOOL HEALTH OFFICE

2026-2027

STUDENT HEALTH FORM

Student's Name _____ **Birthdate** _____ / _____ / _____ **Grade (2026-27)** _____

Health information is vital in planning and supporting students while attending school. Please provide us with current health information each year.

HEALTH CONCERNS: Please **X** if the student has any of the following. *Submit Emergency Plan + Medication Form for* ***** ***conditions.***

_____ **NO HEALTH CONCERNS**

_____ **Allergies*** to _____; reaction_____

Caused by (select): Ingestion (eating allergen) Contact (touching allergen) Airborne (breathing allergen)

Medication (epinephrine) will be submitted to be used, as needed, in school (select): Yes No

_____ Food Intolerance to _____; reaction_____

_____ **Asthma*** _____

Caused by (select): Exercise Irritants (smoke, fragrances, etc) Allergens (pollen, mold, dander, etc)

Medication (albuterol) will be submitted to be used, as needed, in school (select): Yes No

_____ **Diabetes*** (select): Type 1 Type 2

Managed by (select): Diet/Activity Oral medication Insulin injections Pump

_____ **Seizures*** type/description/frequency _____

_____ Behavioral/Mental Health Concern _____

_____ Recent Surgery/Restrictions _____

_____ Other Health Concern _____

Clinic and Doctor _____

Health Insurance _____

Preferred Hospital in the event of an emergency _____

MEDICATIONS: Medication needing to be administered during school hours (both prescription and non-prescription) requires WRITTEN CONSENT BY BOTH PARENT/GUARDIAN AND HEALTH CARE PROVIDER prior to administering (form available upon request).

CONSENT: *I hereby attest to the accuracy of the health information provided for my student. I understand that it is my responsibility to notify the school of any changes to their health status, including new health conditions, needs, medications, and/or allergies. I acknowledge that my student may receive routine vision, hearing, and BMI screenings. I agree to comply with all school policies regarding illness, immunization, and medication. In the event of an emergency, I consent to any necessary medical treatment, including transportation by Emergency Medical Services. The contacts listed below have my permission to pick up my student from school if I am unavailable. Additionally, I authorize school health staff to share relevant health information confidentially with other school personnel and healthcare providers to support my student's health and educational needs.*

_____ _____ _____

Parent/Guardian Printed Name **Parent/Guardian Signature** **Date**

_____ _____

Phone Number(s) **Email**

_____ _____ _____

Emergency Contact 1 Name **Relationship** **Phone Number**

_____ _____ _____

Emergency Contact 2 Name **Relationship** **Phone Number**