



Student Health Information

Student _____ Grade _____ Birth Date _____

Health information is collected to provide for student's health and safety at school. This confidential data will be recorded in the student's health record. It will be shared with school and emergency personnel on a "need to know" basis. You are not legally required to supply this information, but lack of data may impact planning for your student.

NOTE: Immunizations are required for school entrance. See school immunization paperwork for more information.

Parent/Guardian-please check if your student has any of the following:

- NO HEALTH CONCERNS**
- ADHD/ADD (Attention Deficit Disorder) Takes ADHD/ADD medication
- Allergies (please list): _____
- Asthma Other Breathing Problems: _____
- Diabetes: Type I Type II
- Hearing Impairment Hearing device
- Immune Deficiency Condition: _____
- Mental Health Concerns (Depression, OCD, etc.): _____
- Migraine Headaches
- Mobility Issues (problems with muscle, bone, balance, etc.): _____
- Seizures
- Sickle Cell
- Vision Impairment Glasses/Contacts
- Other: _____

Other Health Questions (please answer all questions)	YES	NO	If yes, please explain
Is physical activity limited in any way?			
Hospitalization/Surgery/Injury past 12 months?			
Any health problems that could result in an emergency?			
Does the student use an inhaler?			
Does the student have an Epi-Pen?			
Will your student take medication at school? <i>Please see School Nurse for required paperwork.</i>			

Licensed Health Care Provider _____ Phone _____

Parent/Guardian Phone _____ Email _____

Parent/Guardian Signature _____ Date _____

PLEASE RETURN TO THE HEALTH OFFICE