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2020 - 2021 Student Health Form

Student's Legal Name _____ Birthdate: ____ / ____ / _____ Gender: _____ Grade: _____

HEALTH CONCERNS: Please **X** and explain if your child has any of the following

**** Submit action plan for starred conditions.***

_____ **No health concerns**

_____ **Allergies*** to _____; reaction_____

_____ Food Intolerance to _____; reaction _____

_____ **Asthma***: _____

_____ **Diabetes***: Type 1 Type 2 Managed by (circle): Diet/Activity Oral meds Insulin injections Pump

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

_____ Heart Condition _____

_____ Concussion / Traumatic Brain Injury - date _____

_____ Social/emotional/behavioral/mental health concerns _____

_____ Recent surgeries, hospitalizations, injuries _____

_____ Activity Restrictions _____

_____ Implanted Devices _____

_____ Special Education / 504 Plan (circle)

_____ Bowel / Bladder Concerns _____

_____ Other Health Concern _____

_____ My child has health insurance _____ (__ I request assistance to obtain this)

Preferred Hospital in the event of an emergency _____

MEDICATIONS: List **ALL** medications that this student takes

**** Please Note: WRITTEN CONSENT IS REQUIRED BY BOTH THE STUDENT'S GUARDIAN AS WELL AS THEIR HEALTH CARE PROVIDER.*** *Complete a Medication Administration Form for **ANY** medication (BOTH PRESCRIPTION AND NON-PRESCRIPTION) needing to be administered **during school hours** (forms are available in the Health Office).*

Medication Name	Dose	Purpose	How Often	Given during school?

I attest to the information provided. I acknowledge that it is my responsibility to inform the school of any changes to the health status of this student including health conditions, needs, medications, and/or allergies. I understand and agree that this student may receive a routine screening for any vision and hearing deficiencies. I will comply with all school illness and medication policies. Furthermore, I give permission for school health staff to confidentially exchange health information - both within the school as well as with outside health care providers - for use in meeting this student's health and educational needs in school.

_____ _____ _____ _____

Parent/Guardian Printed Name (s) **Phone Number (s)** **Parent/Guardian Signature (s)** **Date**

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