STUDENT HEALTH INFORMATION
School Year : _____

STUDENT NAME:_____Birthdate:_____Grade:____School:_____

HEALTH CONCERNS	YES	NO	MEDICATION (Name, dosage)	NECESSARY MONITORING IN SCHOOL	COMMENTS OR DESCRIBE
ASTHMA/ RESPIRATORY					
SEVERE ALLERGIES				FOOD LATEX INSECTS NUTS	type of reaction date of last reaction:
DIABETES				Equipment:	
HEAD INJURY					
SEIZURES/ NEUROLOGICAL/ MIGRAINES					Type & date of last episode
HEART/BLOOD					
MUSCLES/BONES/ JOINTS/SKIN					
BLADDER/KIDNEY					
STOMACH/ INTESTINES/BOWELS					
IMMUNE PROBLEMS					
OTHER HEALTH CONCERNS					
HEARING CONCERNS				Hearing aides? Preferential seating?	
VISION CONCERNS				Glasses or contacts? Reading only?	
GROWTH & NUTRITIONAL CONCERNS					
DEVELOPMENTAL CONCERNS					
EMOTIONAL/ BEHAVIORIAL					

- Routine or daily medications, treatments or therapies (not listed above):
- Activity restrictions in school?
- Special medical equipment required in school? (eg. oxygen, wheelchair)
- Have there been any significant changes in your child's health over the last year? Explain:
- ILLNESSES, HOSPITALIZATIONS, ACCIDENTS/ INJURIES and dates: (use other side if necessary)

Health Care Provider(s) & Phone #:

PARENT/GUARDIAN SIGNATURE_____ HOME/WORK PHONE #_____DATE completed:_____

Name of school nurse: _____ your school nurse can be reached at: _____
Please contact the school nurse directly if you would like to discuss any of the above information that you feel is confidential.