

Annual Student Health Information Form

Please Print:

Student's Last Name _____ First _____ Birthdate _____ Grade _____ M F

Doctor: _____ Phone # _____

Dentist: _____ Phone # _____

Specialist: _____ Phone # _____

History/Medical Diagnosis - Please check any that apply and return to school office

ADHD *Asthma Autism *Diabetes Heart/Lung *Seizure Disorder date of last seizure _____

*Allergies (specify)

Drug Allergies	Food Allergies	Insect/Bee Allergies	Other Allergies

*** Medical diagnoses that impact your child's health and safety during the school day and/or require treatment or accommodations, such as severe food allergies, asthma, etc... will need an Action/Care Plan completed by the physician.**

Hearing Loss/Aids right/left ear Glasses/Contacts distance/near Anxiety

Other Health Information _____

Behavioral Concerns _____

Concerns that might affect performance at school _____

NO KNOWN HEALTH PROBLEMS

Please list medication given at home or school:

Medication _____ Reason _____ Dose _____ Time(s) _____

Medication _____ Reason _____ Dose _____ Time(s) _____

Medication _____ Reason _____ Dose _____ Time(s) _____

*** Any medications to be administered at school requires the completion of Authorization of Medication Administration in School form.**

Print Parent/Guardian: _____ **Date:** _____

Parent/Guardian Signature: _____