STUDENT HEALTH INFORMATION FORM

Child's Name_____

Date of Birth: _____ _____

Mothers Name: _____ Daytime phone: _____

Fathers Name: _____ Daytime phone: _____

Emergency name and phone number of person(s) who could be called when parents cannot be reached:

Name: _____ Relation: _____ Number: _____

Name: _____ Relation: _____ Number: _____

Does your child have any special health concerns? Yes_____ No_____

Asthma* ☐ Diabetes* ☐ Seizure Disorder* ☐ Other* ☐ _____

If other, please explain: _____

_____

***An Individual Health Plan needs to be completed every year for the above health concerns. Please speak with the school nurse regarding this plan.**

Does your child have any Severe Allergies? Yes_____ No_____

Does your child require an EPI PEN for these allergies? Yes_____ No_____

	List allergic item(s):	Describe Reaction:	Date of last reaction:
☐ Food(s)*			
☐ Insect(s)*			
☐ Latex*			
☐ Medication(s)			
☐ Other			

*** An Allergy Action Plan must be filled out every year for the above health concerns and allergies. Forms may be obtained from the school office or downloaded from the school website.**

Please list medications your child is currently taking: _____

_____

Will medications need to be taken during school hours? Yes_____ No_____

If yes, please list: _____

***A Medication Authorization form needs to be completed for all medications needed during school hours**

Please provide any other information or past medical history you think would be important for us to know:

_____

_____

_____

_____

Parent/Guardian Signature _____ **Date**_____