

## 2016 - 2017 Student Health Form

**Student's Legal Name** Last: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_

Birthdate: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Ethnicity: \_\_\_\_\_ Gender: \_\_\_\_\_ Grade: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_  

Street
Apartment #
City
State
Zip Code

**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

*\*Complete a Medication Administration in School Form for any medication needing to be administered during school hours*

<u>Medication Name</u>	<u>Dose</u>	<u>Purpose</u>	<u>How Often</u>	<u>Given during school?</u>

*I attest to the information provided and give permission for its confidential exchange for use in meeting my child's health and educational needs in school. 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.*

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

\_\_\_\_\_  
 Additional Emergency Contact Name                      Relationship                      Phone Number (s)