Cambridge School District
Health Survey/Information

Student Name: _____ Birthdate: _____

Please provide the following information:
Clinic/Physician Name: _____ Phone: _____
Hospital name: _____ Phone: _____

Please check all that apply. When an item is checked, please provide additional information.

☐ Severe reaction to insect stings

Cause/Reaction:

☐ Food Allergies

Cause/Reaction:

☐ Other Allergies

Cause/Reaction:

☐ Epi-pen in School Health office?

☐ Asthma

☐ Mild ☐Moderate ☐Severe

Cause/Reaction:

☐ Inhaler in School Health office?

☐ Heart Condition

Describe:

☐ Vision Loss (not corrected by glasses)

Describe:

☐ Hearing Loss

Describe:

☐ Emotional Problems

Describe:

☐ Diabetes

Describe:

☐ Seizures

Describe:

☐ Migraines/Headaches

Describe:

☐ Physical Limitations

Describe:

☐ Student is taking medication at home that the school needs to be aware of

Describe:

☐ Student will be taking medication at school

List of medications:

Students who require prescription or over the counter medication during school hours must have a current Administering Medication Consent & Release Form completed, signed, and on file is the school office PRIOR TO medication being administered or taken at school. Medication must come in the original container and be appropriately labeled. Click HERE for the Form - Please print and complete a form for each medication to be administered at school.

☐ Please specify and NEW immunization boosters the student has received

☐ Additional pertinent medical information

The parent/guardian signature below allows the school to share student health concern information with school staff members, bus drivers and coaches/advisors that may come in contact with the student.

Signature: _____ Date: _____