YEARLY HEALTH INORMATION

Student_____ M/F Birthdate_____ Grade_____ Date_____

Doctor's Name_____ Phone_____ Preferred Hospital_____

NO MEDICATIONS WILL BE GIVEN AT SCHOOL WITHOUT A SIGNED AUTHORIZATION FORM ON FILE.

Please check any of the following that applies to your child. Give details whenever possible and dates as needed.

Has your Child ever had or currently have any of the following?

	Yes	No	Comments/Explain
Allergies			List all:
Epi Pen at school? Yes/No			Type of reaction:
Food Allergies/Intolerance			List all:
Epi Pen at school? Yes/No			Type of reaction:
Dietary Restrictions			List all:
ADD/ADHD (Circle One)			Medication taken: Yes/No at: School/Home
Anxiety			
Asthma			Inhaler needed at school: Yes/No
			What produces symptoms?
Bleeding Issues			
Bone/Joint Issues			
Dental Problems (Braces)			Dentist name: Last exam:
Diabetes			
Ear/Hearing Issues			Dr. name:
Eye/Vision Issues			Dr. name:
Wears glasses/contacts			*if yes; Last exam:
Headaches			*if yes; Migraines? Yes/No
Heart Issues			
Seizures			
Skin Conditions			
Stomach/Bowel Issues			
Urinary Issues			
Hospitalizations			Reason: Dates:
Surgery			Reason: Dates:
Other Concerns			

PLEASE LIST ALL MEDICATIONS YOUR CHILD IS TAKING:

Medication	Dose	Times	Why is your child taking this medication?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Parent Printed Name_____ Cell Phone_____

Parent Signature_____ Work Phone_____

PLEASE RETURN THIS PAGE

***Information provided is only disclosed with the appropriate staff. ***

Revised 2020