Student Health Summary-ProctorPublic Schools

Please complete and return to school

STUDENT NAME_____GRADE_____ DATE OF BIRTH_____

Part 1

Please check if your student has any of these health conditions:

VISION_____(last exam date)_____ HEART _____ CANCER_____

MENTAL HEALTH_____ HEARING_____ PHYSICAL DISABILITIES_____ SEIZURES_____

If there are NO medical or health conditions, please complete part 1, sign and return to school.

Part 2

Please list ALL medications that are currently prescribed to your child. (daily and as needed medications)

Medication_____Dose_____ Time given_____

Medication_____Dose_____ Time given_____

Is medication required during the school day? Yes or No (circle)

If Yes, you will need to request a *Medication Administration* form from the School Nurse.

Part 3

Please check ALL that apply. Provide as much information as necessary for your child to be safely cared for during the school day. Contact the school nurse with questions/concerns.

ALLERGIES – YES or NO Circle any of the following that apply

Bee sting Food Medication Other_____ How is this allergy managed_____

Medication required_____ *If severly allergic* Contact the School Nurse ASAP

ASTHMA – YES or NO Type_____Triggers_____

How is asthma managed_____(ie.inhaler/nebulizer)

***Please contact School Nurse to submit asthma action plan**

DIABETES – YES or NO Type 1 or 2 (circle) ***Diabetic Management plan required by Doctor***

Hospital preference St. Lukes or St. Mary's (circle)

IF your child HAS a health condition and RIDES the BUS to or from school. This information WILL be shared with the transportation dept. and other school officials AS NEEDED unless you OPT out. Check this BOX to Opt OUT ☐
