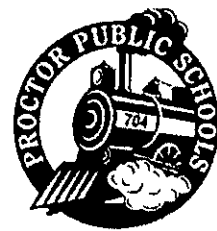


Student Health Summary-ProctorPublic Schools

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 severely 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** ☐