St. Croix Central School District
Student Health Information Form

Student Name_____ DOB_____ Grade_____

Mother's Name_____ Father's Name_____

Student resides/lives with:

_____Both parents _____ Mother _____Father _____Stepmother _____ Stepfather _____Other Specify:_____

Condition	Yes	Comments	Condition	Yes	Comments
Allergies (food, insects, drugs, latex)			Diabetes		
Allergies (seasonal)			Head injury, concussions		
Asthma or breathing problems			Hearing problems or deafness		
Attention-Deficit/Hyperactivity Disorder (ADD or ADHD)			Heart problems		
Behavioral problems			Muscle problems		
Developmental problems			Seizures		
Bladder problems			Sickle cell disease		
Bleeding problem			Speech problems		
Bowel problems			Spinal injury		
Cerebral palsy			Surgery		
Cystic fibrosis			Vision problems		
Dental problems			Other		

Describe any other important health-related information about your child (for example; feeding tube, hospitalizations, oxygen support, hearing aid, dental appliance, etc...)

_____

_____

List all prescription, over-the-counter, and herbal medications your child takes regularly

_____

_____

Does your child require medication during school hours? □ **yes** □ **no**

In order to administer medication (prescription and over-the-counter) during the school day, parents must complete the required medication form which includes parent signature and physician's order (for prescription medication). Forms are available in the health office of each building and on the school webpage.

Signature of person completing this form_____ Date_____

- Please note that school nurse/health assistant may contact you to discuss any of the information as listed above. A health plan may be developed to ensure the safety of your child.