STUDENT HEALTH FORM

6/03

Dear Parents,
The following is a brief health form which must be returned to your child's teacher as soon as possible. This information will be reviewed by the school nurse and used to meet your child's health needs at school and in P.E. Please use a pen and write firmly.

School ______________________ Homeroom Teacher/Grade ______________________

Student Name ______________________ Date of Birth ______________ Home Phone # ______________

Parent/Guardian Name (mother) ______________________ Daytime Phone # ______________

(father) ______________________ Daytime Phone # ______________

Name of Doctor: ______________________ Phone # ______________

Name of Dentist: ______________________ Phone # ______________

Does your child have health insurance? ❑ Yes ❑ No Is your child on a special diet? ❑ Yes ❑ No

Does your child take regular medication? ❑ Yes ❑ No Is your child able to participate in Physical Education? ❑ Yes ❑ No

CHECK CONDITION(S) YOUR CHILD HAS:

❑ 1 Asthma	❑ 7 Convulsions/Seizures	❑ 13 Hemophilia	❑ 19 Skin problems
❑ 2 ADD/ADHD	❑ 8 Cystic Fibrosis	❑ 14 Heart Problems	❑ 20 Speech Problems
❑ 3 Bone/Muscle Problems	❑ 9 Cerebral Palsy	❑ 15 Hearing Problems	❑ 21 Kidney?Bladder
❑ 4 Bowel Problems	❑ 10 Dizziness/Fainting	❑ 16 Physical Disability	❑ 22 Vision Problems
❑ 5 Cancer/Leukemia	❑ 11 Diabetes	❑ 17 Severe Allergies	❑ Other ________
❑ 6 Nose Bleeds	❑ 12 Emotional/Behavioral	❑ 18 Sickle Cell Anemia	❑ 24 NONE

For those illnesses or developmental problems checked above, please provide additional information:

Severe Allergies
What is your child allergic to? ______________________
Is emergency medication needed at school for allergies? ❑ Yes ❑ No
Circle the type of allergic reaction that occurs. Hives Swelling Difficulty Breathing Other: ________

Asthma
What triggers an episode? ______________________
Circle when medication is needed at school. Daily Before P.E. Never When Symptoms Occur

Diabetes
Is insulin needed at school? ❑ Yes ❑ No Are snacks needed at school? ❑ Yes ❑ No
Will blood sugar checks be needed at school? ❑ Yes ❑ No

Seizures
How often do seizures occur? ______________________
Is medication needed at school? ❑ Yes ❑ No

Vision Problems
Does your child wear glasses or contacts? ❑ Yes ❑ No Is special seating needed? ❑ Yes ❑ No

Hearing Problems
Does your child have a known loss? ❑ Yes ❑ No Is special seating needed? ❑ Yes ❑ No
Does your child have a hearing aid? ❑ Yes ❑ No

Heart Problems
Circle type: Heart Murmur Heart Valve Condition Other: ______________
Is exercise limited? ❑ Yes ❑ No Is medication needed at school? ❑ Yes ❑ No

Head Injury
Has your child had a concussion in the past 12 months? ___Yes ___NO
Please describe: ______________________

Bone? Orthopedic Problems - Name of problem: ______________________

Other Heath Problems or Learning Problem: ______________________

If your child needs medication, a special diet, or P.E. restrictions at school, please contact the school nurse. Additional forms signed by the doctor will be necessary.

I give my permission for routine health screenings to be performed (height, weight, vision, hearing, and dental). I understand I will be notified of any possible problems detected.

Parent or Guardian Signature ______________________ **Date** ______________