USD 231
Gardner Edgerton School District

HEALTH SERVICES DEPARTMENT

Student Health Information

Revised: 01.12.2021

Student's Name (Last, First, MI): _____ Male/Female

Birthdate:_____ Name of School:_____ Grade: _____

Parents/Guardian: _____

ASSESSMENT OF STUDENT HEALTH

To the best of your knowledge has your child had any problems with the following? If yes, please comment.

	Yes	Comments
Allergies (please list)		*Requires Food Allergy Action Plan signed by a Physician*
Asthma		*Requires Student Asthma Action Card signed by a Physician*
Seizures		*Requires Seizure Action Plan signed by a Physician*
Diabetes		*Requires orders signed by a Physician*
Hospitalizations/Surgeries		
ADD/ADHD		
Emotional/Behavior Disorder		
Birth Defects		
Bleeding Problems		
Dental		
Ear Problems/Hearing Loss		
Eye or Vision Problem		
Migraines/Frequent Headaches		
Heart Problem		
Limits of Physical Activity		
Problem with bladder		
Problem with bowels		
Other		

Does your child take any medications? YES NO. If so, please list them here:

_____

Will any of these medications be given at school? YES NO. If so, a physician's order is required.

Will your child require special treatment or procedure while at school? YES NO. If so, please describe.

_____

Parent/Guardian Signature: _____Date: _____