SCHOOL TOWN OF HIGHLAND
HEALTH SERVICES
HEALTH INFORMATION SHEET

It is very important that we have up to date health information on your child. This information is kept confidential and is essential to provide the best possible care for our students. Thank you for your cooperation in this matter.

CHECK THE CONDITIONS THAT PERTAIN TO YOUR STUDENT (give year if applicable)

Chicken pox (month/year)
Scarlet Fever
Mumps
Measles
Frequent Colds
Anxiety/Depression
Diabetes
Allergies (type)
Seizures
Hearing Problems
Vision Problems

Dizziness/ Fainting
Skin Problems
Gastrointestinal Problems
Dental Problems
Frequent Nosebleeds
Frequent Headaches
Orthopedic Problems
Blood Disease
Kidney/ Bladder Problems
Ear Infections
Tubes in ears? Y or N Date(s)

Has your child been diagnosed with asthma?
Is the student on any medication(s)? If so, please list medication/ dosage(s)

Will the student be taking the medication at school?
Has your child had any allergic reactions to medication, foods, or insects? If so, describe care required.

Please list any hospitalizations/ surgeries/ significant illnesses or injuries, if any, your child has had.

Does the student wear contacts or glasses? Date of last eye exam
Has your child been diagnosed as ADD/ADHD? If so, is your child on any type of medication for it?

Do you have any concerns about your child's general health? (eating, sleeping habits, weight, teeth, etc.)

** If needed, please feel free to contact the school nurse for a confidential conference**

Student's Name Grade Date of Birth

Last School Attended City State

Parent/Guardian Date

Person to contact if your child becomes ill at school:

1.) Phone:

2.) Phone:

3.) Phone:

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