School Health Information Form

Student Name _____

Please complete this form prior to the first day of school. **Emergency contact information, and names of your physician and dentist should be updated annually on your** *Student Information Form provided by the office manager.*

Date of last Pediatrician/physician visit _____ Date of last Dental visit _____

If your child has had immunizations in the last year, please submit a copy of the official updated immunization record. The immunization name, month, day, and year should be listed.

List any medical conditions such as diabetes, epilepsy, asthma, ADHD, significant illnesses or injuries:
_____
_____

List any Allergies, including food and insect stings:
_____

Are there any health problems that would require school modifications for your child's participation in physical education, field trips, or other school activities? No__ Yes__
If yes, please explain:
_____
_____

My child's physician has determined that my child is able to participate in the full school program as described in the program description, including physical education. No___ Yes___

Current Medication(s)
_____
If a prescription medication is needed during school hours, a new physician signature is required for the new school year.

Emergency Medication(s) (ie. Epinephrine, Glucagon, Diastat)
_____ *If your child has an emergency medication, a new Emergency Action Plan, signed by your physician, is required for each new academic year.*

Student use an inhaler? No___ Yes___ Type/Medication
_____Will your child need an inhaler in school? No___ Yes___

Student wear glasses? No__ Yes__ Any other vision issues?

_____ Student have a hearing aid? No__ Yes__

Any other hearing issues? _____

List any concerns with psychiatric, social, or behavior issues
_____
_____
_____
_____

Names and ages of siblings

_____

___

The information on this form may be shared with my child's teachers on a need to know basis:
Yes_____ No_____

_____   _____
                    Parent Signature   Date