

# Ascension Catholic School

APPENDIX 3

2.123

## Annual Student Health Information Form

Please Print:

Student's Last Name \_\_\_\_\_ First \_\_\_\_\_ Birthdate \_\_\_\_\_ Grade \_\_\_\_\_ M  F

Doctor: \_\_\_\_\_ Phone # \_\_\_\_\_

Dentist: \_\_\_\_\_ Phone # \_\_\_\_\_

Specialist: \_\_\_\_\_ Phone # \_\_\_\_\_

**History/Medical Diagnosis** - Please check any that apply and return to school office

ADHD  \*Asthma  Autism  \*Diabetes  Heart/Lung  \*Seizure Disorder date of last seizure \_\_\_\_\_

\*Allergies (specify)

Drug Allergies	Food Allergies	Insect/Bee Allergies	Other Allergies

**\* Medical diagnoses that impact your child's health and safety during the school day and/or require treatment or accommodations, such as severe food allergies, asthma, etc., will need an Action/Care Plan completed by the physician.**

Hearing Loss/Aids right / left ear  Glasses/Contacts distance / near  Anxiety

Other Health Information \_\_\_\_\_

Behavioral Concerns \_\_\_\_\_

Concerns that might affect performance at school \_\_\_\_\_

**NO KNOWN HEALTH PROBLEMS**

Please list medication given at home or school:

Medication \_\_\_\_\_ Reason \_\_\_\_\_ Dose \_\_\_\_\_ Time(s) \_\_\_\_\_

Medication \_\_\_\_\_ Reason \_\_\_\_\_ Dose \_\_\_\_\_ Time(s) \_\_\_\_\_

Medication \_\_\_\_\_ Reason \_\_\_\_\_ Dose \_\_\_\_\_ Time(s) \_\_\_\_\_

**\* Any medications to be administered at school requires the completion of Authorization of Medication Administration in School form.**

Parent/Guardian Name (print): \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_