Annual Student Health Information Form

Please Print:

_____ _____ _____ _____ M ☐ F ☐
Student's Last Name First Birthdate Grade

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: _____