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 <u>any</u> 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.**

Print Parent/Guardian: ______________________________ **Date:** ________________

Parent/Guardian Signature: ______________________________