Annual Student Health Information

Please print:

_____ _____ _____ ____ __M ___F

Last name First name Birthdate Grade

History/Medical Diagnosis

Please check any that apply:

__ADHD __Anxiety __*Asthma __*Diabetes __*Seizure Disorder (date of last seizure)_____

***Allergies (please specify)**

Drug allergies:_____

Food allergies:_____

Other allergies;_____

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

__Hearing loss/Aids __Glasses/contacts

__Other health information _____

__No known health problems

Medications

Please list all medications given at home and/or school:

Medication_____Reason_____Dose_____Time_____

Medication_____Reason_____Dose_____Time_____

Medication_____Reason_____Dose_____Time_____

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

Parent/Guardian Name (print):_____

Parent/Guardian SIgnature:_____Date_____