

STUDENT HEALTH INFORMATION

GRADE _____

STUDENT NAME: _____

PARENT/GUARDIAN: _____ Phone-Home _____

Work _____

Emergency contact if parent is not available:

1. _____ Phone _____

2. _____ Phone _____

STUDENT MEDICAL HISTORY:

Frequent earaches, infections, colds

Frequent nosebleeds

Heart conditions

Kidney or bladder trouble

Physical defects

Asthma

Eczema/skin trouble

Tuberculosis

Diabetes

Frequent headaches

Speech problem

Convulsions/seizures

Hearing problem

Scarlet fever

Rheumatic fever

Allergic reaction requiring

Other health issues

medication

***Please explain special health problems _____

ALLERGIES:

___ plants ___ foods ___ animals ___ bees or insect sting requiring medication

___ drugs ___ other

**Describe allergic reaction and treatment _____

**Do any health problems affect his/her school participation? YES ___ NO ___ If YES,

please explain _____

**Is student required to take any medications or treatments? YES ___ NO ___ If YES,

please explain _____

Does the student wear glasses _____ contact lenses _____ ?

***I understand that the information given above may be shared with staff who have a need to know. In the case of a medical emergency, I give district staff my permission to seek medical attention for the above named student at the nearest medical emergency facility. I understand that I will be notified as soon as possible by district staff.

PARENT SIGNATURE: _____ DATE: _____

MEDICAL INSURANCE COMPANY: Name _____

Policy Holder _____ Policy Number _____