SCHOOL HEALTH INFORMATION FORM

STUDENT INFORMATION

Name DOB / / Gender M F

Teacher Grade Parent/Guardian Name

Phone # Phone # Email

HEALTH HISTORY

Check all conditions your child currently has or has been treated for in the past

	CONDITION	EXPLAIN
	Diabetes	
	Seizures	
	Allergies	
	Asthma	
	Lung/Respiratory Disease	
	Heart/Cardiovascular Conditions	
	Head Injury/Concussion	
	Behavioral or Emotional Difficulties	
	Neurological Disorders	
	Attention Disorders (ADD,ADHD)	
	Mental Health Conditions (e.g., anxiety, depression)	
	Fainting Spells and Dizziness	
	Kidney/Bladder Conditions	
	Ear/Eyes/Nose/Sinus Problems	
	Muscle or Bone Conditions	
	Abdominal/Stomach/Digestive Problems	
	Migraines or Severe Headaches	
	Food Restrictions/Special Diet	
	Skin Conditions	
	Mobility Problems or Activity Restrictions	
	Learning Problems	
☐	VISION CONCERNS	Glasses/Contacts Yes No For: Last professional eye exam / / Results:
☐	HEARING CONCERNS	Hearing Device Yes No Type: Right Left Both ears
☐	**List any other medical conditions:**	

MEDICATIONS

List all prescription, over-the-counter, and medications taken as needed (e.g., EpiPen, inhalers, pain relievers)

Medication	Dose	Frequency	Reason

Would you like to schedule a conference with the licensed school nurse to discuss a particular health concern? Yes No

Indicate your concern(s):

The information you provide will only be shared with school staff who require access to this information to meet your child's health and safety needs while at school. Not providing complete and accurate information may result in an incomplete health and safety plan for your child.

Parent/Guardian signature ____________________ Date / /

FOR OFFICE USE ONLY: charted: ________ *(initial)*

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