Student Health Information Sheet

Please complete the requested information and add any information about your child's health that would be helpful to the school. Guardian MUST notify school of any changes in phone #'s!

Current Grade: _____ Current School Year: _____

Student's Full Name: _____ Male _____ Female _____ DOB: ____/____/____

Primary Guardian's Name: _____

Primary Guardian's Address: _____

Primary Guardian's Home Phone #: _____ Cell #: _____

Relationship of Guardian to Student: _____

Secondary Guardian's Name: _____

Secondary Guardian's Address: _____

Secondary Guardian's Home Phone #: _____ Cell #: _____

Relationship of Guardian to Student:

_____

****REQUIRED** Emergency Contact Name: _____**

Emergency Contact Phone #: _____

****The Emergency Contact will be contacted if school staff is unable to reach either Guardian listed above.****

It is PERMISSIBLE for my child to take:

Tylenol/Acetaminophen	☐ **Yes**	☐ **No**
Ibuprofen	☐ **Yes**	☐ **No**
Tums/Antacids	☐ **Yes**	☐ **No**

X_____ **X**_____

Parent/Guardian Signature **Date**

**** I consent to allow school personnel to call doctor/911 in case of emergency and unable to reach parents. ****

****PLEASE CONTINUE THIS FORM ON THE BACK****

Does your Child receive Medicaid? Yes _____ No _____ Medicaid #: _____

Current Dentist: _____ Current Doctor: _____

Please list any prescription and over the counter medications that your child will need during the school day:_____

Please list any prescription and over the counter medications that your child takes at home:

_____

****All medications to be administered at school should be labeled and in the original bottle and must have written permission signed by parents (in Nurse's office.) Medications (except inhalers) must be kept in the Nurse's office at his/her school. If medication is discontinued or it is the end of the school year, medications will be discarded after five school days. We will make every effort to contact you.**

HEALTH CONDITIONS PAST AND/OR PRESENT (Check all that apply)

☐ **Heart Condition /Restrictions at school: _____**

☐ **Seizure Disorder /Please specify & give date of last seizure: _____**

☐ **Bowel & Bladder/Please specify: _____**

☐ **Hearing Impaired/Please specify: _____**

☐ **Respiratory Disease/Please specify: _____**

☐ **Will Inhaler be needed at school: _____**

☐ **Diabetes/Please specify: _____**

☐ **Bone/Muscle Joint Problems/ Please specify: _____**

☐ **Celiac (Dr. Note required for Gluten free school breakfasts or lunches)**

_____

☐ **Headaches/Migraines Triggers & Treatments: _____**

☐ **Food Allergies/Specify reaction: _____ Epipen: _____**

☐ **Other Allergies/Specify reaction: _____ Epipen: _____**

☐ **Food Intolerance/Please Specify _____**

Do any health and/or medical conditions require school restrictions, modifications and/or intervention?

☐ **Yes** ☐ **No If yes, please explain: _____**

Does the student require any special procedures and/or treatments for their health conditions?

☐ **Yes** ☐ **No If yes, please explain: _____ (Revised 4/2022)**