Health Information

Student Name____ Date____________

Entering Grade:____________

The following information is only to aid teachers and staff in caring for your child during the school day. Please up-date of any changes through out the year.

Does your child have any HEALTH or MEDICAL concerns that might influence his/her progress in school?

___ TB
___ Asthma
___ Hearing
___ Diabetes

___ Frequent Headaches
___ Frequent Nose Bleeds
___ Vision Problems - my child wears glasses/contacts
___ Allergies - environmental - food - medication

List
Allergies:____

___ My child has an Epi-pen that will be brought and kept at school

Other Health Issues we should be aware of:

Medications Taken :

Additional Comments
Concerns:____

PLEASE NOTE -

If medications are needed at school, a **REQUEST FOR MEDICATION** form must be **signed by your medical care provider** in order for medications (<u>of any kind - including over the counter</u>) to be taken at school.