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 update any changes throughout 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- Glasses/Contacts
____ Allergies- Environmental, Food, or Medical

List Allergies:

____ My child has an Epi-Pen that will be brought and kept at school.

Other Health Issues we should be aware of:
____
____

Medication(s) Taken:
____
____

Additional Comments/Concerns:
____
____

-Please Note-

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