

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 throughout the year.

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

- | | |
|-----------------------------------|--|
| <input type="checkbox"/> TB | <input type="checkbox"/> Frequent Headaches |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Frequent Nose Bleeds |
| <input type="checkbox"/> Hearing | <input type="checkbox"/> Vision Problems - my child wears glasses/contacts |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Allergies - environmental - food - medication |

List all

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 (of any kind - including over the counter) to be taken at school.