



Student Health Information (Required Yearly by Schools)

To insure the health and safety of your child, the information on this form will be shared with school district staff or emergency personnel based on their need to know and/or to support the wellbeing of your child.

Student Name: _____ Date of Birth: _____ Grade: _____

Physician / Clinic: _____ Phone: _____

Dentist: _____ Phone: _____

Hospital Preference: _____ School Year: _____

Health Concern	Yes	No	Medication (Name & Dosage)	In School Monitoring Required	Comments, Concerns, Notes or Describe Actions or Outcomes
Asthma or Respiratory					
Severe Allergies <i>Food / Latex / Insects</i>					
Diabetes					
Head Injury					
Seizures or Neurological					
Heart or Blood Issues					
Muscles, Bones, Joints or Skin					
Bladder or Kidney					
Stomach, Intestines or Bowels					
Immune Issues					
Emotional or Behavioral					
Hearing Concerns <i>Hearing aids or Seating</i>					
Vision Concerns <i>Glasses or Contacts</i>					
Growth Concerns or Nutritional Concerns					
Developmental Concerns					
Other Health issues or concerns					

If your child becomes ill or injured, the school will attempt to call the parent/guardian at home or at work. If you cannot be reached, the school will attempt to call the emergency contact. In case of serious accident/injury/illness, 911 will be called if necessary.

Signature: _____ Date: _____