

**Student Health Information**  
**Must be Updated Yearly and Returned to your school ASAP**

Student Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Grade \_\_\_\_\_

Physician/Clinic \_\_\_\_\_ Phone Number \_\_\_\_\_

Dentist \_\_\_\_\_ Phone Number \_\_\_\_\_

Hospital Preference \_\_\_\_\_

To insure the health and safety of your child this information may be shared with school district staff or emergency personnel based on a need to know.

Health Concerns	Yes	No	Medication (Name, dosage)	Necessary Monitoring in School	Comments or Describe
Asthma/ Respiratory				Inhaler at School? Y N	
Severe Allergies				Food Latex Insects	Type of reaction:  Date of Last reaction:
Diabetes					
Head Injury					
Seizures/ Neurological					Type and date of last episode
Heart/ Blood					
Muscles/Bones/ Joint/Skin					
Bladder/Kidney					
Stomach/ Intestine/Bowels					
Immune Problems					
Emotional/ Behavioral					
Hearing Concerns				Hearing Aide? Preferential seating?	
Vision Concerns				Glasses or Contacts? Reading Only?	
Growth/Nutrition Concerns					
Developmental Concerns					
Other Health 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: \_\_\_\_\_