Student Health Information
2015-2016

Today's Date____/____/_____

Nurse's Initials: (Office Only) _____

Student Name:_____ DOB:_____

Parent/ Guardian_____

Home Phone:_____ Work : _____ Cell: _____

Grade:_____ Teacher: _____

Please complete and sign below. This information will be shared with health care providers and school staff, as needed, to best care for your child while at school.

_____ My Child has no known medical/health conditions (please check if applicable)

Medical Condition	(x) if Yes	Describe	Medications for Condition
ADD/ADHD			
Autism/Asperger's/ Tourette's			
Social/Emotional/ Behavioral			
Psychological Disorders			
Allergy to: _____ Medication(s) _____ Food(s) _____ Grass/Pollen _____ Bee/Wasp _____ Ant Bite _____ Other			Epipen Yes/No Benadryl Yes/No
Asthma		Date of Last Episode	Rescue Inhaler Yes/No
Cerebral Palsy		Walking Aid: Yes/No	
Cystic Fibrosis			
Diabetes		Insulin: Yes/No Pump: Yes/No	Oral Meds:
Eating Disorder			
Epilepsy (Seizures)		Date of Last Seizure:	
Genetic Disorder			

(Down's Syndrome/other)			
Gland/ Organ Disorder			
Headache/Migraine			
Heart/Blood/Bleeding Problem			
High Blood Pressure			
Kidney Disease/Disorder			
Menstrual Problems			
Multiple Sclerosis Muscular Dystrophy Spina Bifida		Walking Aid:	
Orthopedic Problems			
Overweight/Obesity			
Sickle Cell Anemia			
Stomach Problems		Reflux: _____ Chron's:_____ IBS:_____	Medicine/Diet:
Special Diet			
Vision/Hearing Impaired		Glasses/Contacts	Hearing/Speech
*Daily or occasional Prescription Medication?			
*Medications Needed At School		**Prescription Medication Form Must Be Kept on File At School**	
Additional Information			

Please Provide the following information:

1) Name and Address of Insurance Company:_____

2) Policy Holders Full Name:_____

3) Policy Number: _____

4) Phone Number of Insurance Company_____

Physician's Name: _____ **Dentist's Name:**_____

Parent/Guardian Signature: _____ **Date:** _____