Health Information Form

PLEASE USE INK, not pencil

Student's Name _____ _____ _____ _____

Last, First Middle Birthdate Age Grade

1. Has student had any of the following **problems or injuries?** (Examples in parenthesis)
Describe problem for each ☒Yes on the lines at the bottom of the page ↓.

Surgery --Date of any surgeries:	☐Yes ☐No
Head Injury or **Concussion**	☐Yes ☐No
Ear infections *(often has them, ear tubes, etc)*	☐Yes ☐No
Nose problems *(sinus infections, nose bleeds)*	☐Yes ☐No
Eye problems *(blurry vision, wears glasses, lazy eye)*	☐Yes ☐No
----Should wear glasses or contacts to see ☐ far away ☐ read	
Hearing problems *(has trouble sometimes, wears hearing aid)*	☐Yes ☐No
Mouth or throat problems *(Strep throat, swallowing problems)*	☐Yes ☐No
Constipation *(problems having a bowel movement (BM))*	☐Yes ☐No
Problems peeing *(bed wetting, pain when peeing)*	☐Yes ☐No
Back problems *(crooked back, back pain)*	☐Yes ☐No
Muscle and bone problems *(weak muscles, pain in joints)*	☐Yes ☐No
Skin problems *(acne, flaking skin, rashes, hives)*	☐Yes ☐No
Seizures *(shaking fits or convulsions)*	☐Yes ☐No
ADD/ADHD *(problems paying attention, sitting still)*	☐Yes ☐No
Breathing problems *(cough, asthma)*	☐Yes ☐No
Heart problems *(fast or irregular heartbeat, murmur, birth defect)*	☐Yes ☐No
Feelings or emotions *(depression, anxiety, fears)*	☐Yes ☐No
Other:	☐Yes ☐No

Did you mark ☒yes for any problems above? **Tell us more here:** _____

_____

_____

2. Does student have any **allergic reactions** (bad effects) from any of the following? (Check all that apply.)

☐ Outside or Indoor allergies, (*for example: hay fever, grass, pollen, cats ...*) **Please list below ↓**
☐ Food Allergies (*for example: peanuts, milk, wheat ...*) **Please list below ↓**
☐ Insect or Animal Allergies (*for example: bees, wasps, cats...*) **Please list below ↓**
☐ Medicine or shots (*immunization*). **Please list below ↓**
☐ **No, my child has no allergies that I know of.**

Student is allergic to:	**What happens when he/she has a reaction?**

Student is allergic to:	What happens when he/she has a reaction?

Does student have an Epi-Pen? ☐ Yes ☐ No If YES, please bring one to school

3. Has student ever been a **patient in a hospital** (other than a few days after birth)?

☐ No

☐ Yes (If yes, explain why and when below.)

Student was in the hospital because:	Age
Example: Bike accident-concussion	5 years old

4. Does student take any **prescription medicines**? Or have an inhaler or breathing treatments?

☐ No.

☐ Yes - Please list below

Albuterol inhaler	Before exercise	asthma

5. Does student take **over-the-counter medicine**?

☐ Vitamins

☐ Herbal medicine (please list)_____

☐ Other medicines like Tylenol, Advil or something else? (Please list)_____

_____

☐ None, my child does not take any over-the-counter medicines regularly.

By signing below I give permission for this school to contact student's medical clinic IF NEEDED to obtain medical information regarding this student's health including medications.

Student's medical clinic is: _____ **or Student needs a clinic**_____

_____	_____	_____
Signature of person completing this form	**Relationship to student**	**Date**

** Please note: Confidential information about your student's health may be shared only with other school staff that need to know to protect your child's safety. They are told to keep this health information private and not to share with anyone else. If there is health information you would like not to be shared, please contact the school nurse.*