HEALTH INFORMATION FORM

School Year_____

Instructions: Complete front and back side of form and return it to the school office.

Student's Name_____ DOB_____

	Check next to any condition or illness that applies to your child. Use "Comments" section at the bottom of the page for explanations.
1	**Allergies** ☐ Food _____ ☐ Medicine_____ ☐ Insects (please specify)_____ ☐ Environmental ☐ Latex ☐ Other (please specify)_____ **Specify reaction to allergy or allergen** ☐ Rash ☐ Swelling ☐ Hives ☐ Trouble Breathing ☐ Vomiting ☐ Diarrhea ☐ Local Reaction ☐ **Takes medication for any allergies: Name medication(s)**_____ Does the child need a special diet? ☐ Yes ☐ No (If yes, school requires a prescription from doctor.)
2	☐ **Asthma:** List triggers_____ Diagnosed at age_____ ☐ Takes medication: Name medication(s)_____ Under doctor care now? ☐Yes ☐ No
3	☐ Other frequent **Respiratory Conditions:** Describe_____
4	☐ **Attention Deficit/Hyperactivity Disorder** (ADD/ADHD) ☐ Takes medication: Name medication_____
5	☐ **Blood disorder** Please specify (ex. Sickle cell anemia, etc.)_____
6	☐ **Blood pressure** ☐ High blood pressure (hypertension) ☐ Low blood pressure (hypotension)
7	☐ **Cancer:** Please explain_____
8	☐ **Convulsion or seizure:** Type:_____ How long ago was last one?_____ ☐ Takes medication: Name medication_____
9	☐ **Cystic Fibrosis** ☐ Takes medication: Name medication_____
10	☐ **Diabetes** ☐Type 1 ☐ Insulin pen/injection ☐ Pump ☐ Type 2 ☐ Medication_____
11	☐ **Digestive disorders** (ex. IBS, Crohns) Please specify_____
12	☐ Serious **head injury:** Explain_____
13	☐ **Hearing trouble** ☐ Uses hearing aid
14	☐ **Heart condition:** Explain_____ Under doctor's care for this condition? ☐Yes ☐ No **Any physical restrictions?** ☐ Yes ☐ No If yes, explain_____
15	☐ **Kidney or bladder disorder** Explain_____
16	☐ **Migraines:** Under doctor's care for this condition? ☐ Yes ☐ No ☐ Takes medication: Name medication_____
17	☐ **Muscle/bone/mobility disorder** Explain_____
18	☐ **Psychiatric diagnosis** _____ ☐ Takes medication: Name medication_____
19	☐ **Surgery:** What for_____
20	☐ **Vision** problems: Explain ☐ Glasses ☐ Contacts
21	☐ **Other medical condition(s) not listed:** Explain
22	☐ **My child does not have any of the listed conditions or illnesses.**

Comments or other health information_____

_____

_____

Parent/Guardian Signature **Date**