Grade _____ 2018/2019

Request for Health Information

Must be completed annually

Student's Name:_____Date of Birth:_____
Parent's Name:_____
Mailing Address: _____
E-MAIL address:_____
Phone: Home _____ Mom's Work: _____ Mom's Cell: _____
Dad's Work: _____ Dad's Cell: _____
Emergency Contact: _____Phone: _____
Does the student have any drug allergies? __Yes___No
If yes, please list: _____
Health Care Provider Name: _____ Clinic: _____

___MY CHILD DOES NOT HAVE ANY KNOWN MEDICAL CONDITIONS. (You may stop here if there are no known medical conditions. Please sign the back page and return to school).

Asthma ___ Yes___ No

Triggers: ___environmental ___seasonal ___exercise induced ___upper respiratory infection
___ other _____
Will your child have an inhaler at school? ___Yes ___No If yes, location of inhaler: ___Health Office ___Carried by Student

Anaphylaxis Allergy ___Yes ___No

Allergen: ___Bee Stings ___Latex ___Medications ___Other _____
Will your child have an epipen at school? ___Yes ___No If yes, location of epipen: ___Health Office ___Carried by Student
Date and Description of Last Reaction:
_____

Food Allergy ___Yes ___No

__Peanuts __Tree Nuts __Milk __Egg __Wheat __Soy __Fish __Shellfish __Other:_____
Will your child have an epipen at school? ___Yes ___No If yes, location of epipen: ___Health Office ___Carried by Student
Date and Description of Last Reaction:
_____

Seizures ___Yes ___No

Type:_____
___controlled with medication ___on medication, continues with seizures ___no medication needed at school
___Emergency seizure medication needed at school and type_____
Date and Description of Last Seizure:
_____

Diabetes ___Yes___No

___Type I ___Type II Diagnosis Date: _____
Insulin by: ___Pump ___Injections Independent with all care: ___Yes ___No

Other conditions or specific information to help us better serve your child:_____
_____
_____

Does your child take routine medications? ___Yes ___No
Does your child need to take medications at school? ___Yes ___No
List medications and what they treat: whether taken at school or at home
_____
_____

This information will be shared with staff members on a need to know basis to help ensure your child's health, safety and school success. I give permission to the school nurse/health assistants to share information regarding my child's medical condition(s) with my physician or emergency personnel.

Parent/Guardian Signature: _____ Date: _____