STUDENT HEALTH INFORMATION UPDATE

School Year: _____

Student Name: _____ Birthday: _____ Grade: _____

Health Care Provider: _____ Dentist: _____

Please check yes or no and explain when necessary

ADD/ADHD	O yes O no	Diabetes	O yes O no
Allergies to animals (explain)	O yes O no	Head injury/concussion	O yes O no
Allergies to food (explain)	O yes O no	Heart problems (explain)	O yes O no
Allergies to insects (explain)	O yes O no	Kidney/urinary problems (explain)	O yes O no
Allergies to medication (explain)	O yes O no	Migraines	O yes O no
Allergies/environmental (explain)	O yes O no	Nutritional/growth issues (explain)	O yes O no
Asthma Inhaler at school or home? (circle)	O yes O no	Orthopedic (bone/joint) problems (explain)	O yes O no
Autism/Asperger's	O yes O no	Seizures/neurological problems (explain)	O yes O no
Behavioral issues	O yes O no	Stomach problems (explain)	O yes O no
Bipolar disorder	O yes O no	Activity restrictions in school? Explain	O yes O no
Depression	O yes O no	Other (explain)	O yes O no
Developmental delay	O yes O no		

Student Vision and Hearing Conditions

Does your child have vision problems?	O yes O no	If yes, are glasses/contacts worn for reading at close range? If yes are glsses/contacts worn for distance vision?	O yes O no O yes O no
Does your child have hearing problems?	O yes O no	If yes, is a hearing aid worn? If yes, is preferential seating needed?	O yes O no O yes O no

Student Medications (List medications student is taking)

Name of medication:	For what condition?	Does this medication need to be given at school?

As parent/guardian of the above named student, I give permission for this information to be shared with individuals in the school setting who have a legitimate need to know based on my child's educational and safety needs.

Parent/Guardian Signature: _____ Date: _____