CURRENT HEALTH INFORMATION 2019-20

Student ______________________ Birthdate ____________ Grade __________
Address ______________________ City ____________ Zip __________
Parent/Guardian ______________________ Home Phone ____________ Work Phone __________
Physician ______________________ Address ______________________ Phone __________
Dentist ______________________ Address ______________________ Phone __________

Yes	No	*PLEASE CHECK ONLY THOSE ITEMS DIAGNOSED BY A DOCTOR*
____	____	Asthma? Medications used (including dosage): ______________________
		______________________
____	____	Diabetes? Insulin ______________________
____	____	Seizures or Epilepsy? Type of seizures: ______________________
		Medications used ______________________
____	____	Heart disease or bleeding disorder? Medications used: ______________
		______________ Any precautions/restrictions ______________
____	____	Allergies. Food: __________ Medication: __________ Other: __________
		______________ Medications used: ______________
		Epi-pen at school _____ Yes _____ No
____	____	Physical Disability – Specify: ______________________
____	____	Does your child wear corrective lenses?
____	____	Serious illness, surgery, or accidents during the PAST YEAR that may affect school performance – Specify: ______________________
____	____	Is your child taking any other medications? Medication name and dosage:
		______________ Reason for medication: ______________
____	____	Must medication be taken during school hours? (If yes, obtain appropriate forms from the school office.)
		All Other Health Concerns: ______________________
		______________________

Additional information you care to share: ____
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I understand this information will be shared in a confidential manner with my child's teacher(s) and the Public Health Nurse consultant to the school and/or the school nurse to best meet the health and education needs of my child.

Signature of Parent/Guardian ______________________________