



# CURRENT HEALTH INFORMATION 2020-21

Student	_____	Birthdate	_____	Grade	_____
Address	_____	City	_____	Zip	_____
Parent/Guardian	_____	Home Phone	_____	Work	_____
Physician	_____	Address	_____	Phone	_____
Dentist	_____	Address	_____	Phone	_____

<u>Yes</u>	<u>No</u>	<i>PLEASE CHECK ONLY THOSE ITEMS DIAGNOSED BY A DOCTOR</i>
_____	_____	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?
_____	_____	<u>Serious</u> illness, surgery, or accidents during the <u>PAST YEAR</u> 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: _____ _____
_____	_____	Date of Last Physical: _____

Additional information you care to share: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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 \_\_\_\_\_