Annual Student Health Information Form

Please Print
Student Name_____DOB_____Grade_____ M ☐ F ☐

Doctor:_____Phone #_____

Dentist_____Phone #_____

Specialist_____Phone #_____

Mother_____ Home #_____ Work # _____ Cell #_____

Father_____ Work #_____ Cell #_____

History/Medical Diagnosis - Please check any that apply
☐ ADHD ☐ *Asthma ☐ Autism ☐ *Diabetes ☐Heart/Lung
☐ *Seizure Disorder (date of last eizure)_____
☐ *Allergies (specify)

Drug Allergies	Food allergies	Insect/Bee allergies	Other allergies

***Medical diagnoses that impact your child's health and safety during the school day and/or require treatment or accommodations, such as severe food allergies, asthma, etc., will need an Action /Care Plan completed by the physician.**

☐ Hearing Loss/Aids right/left ear ☐Glasses/Contacts distance/near ☐ Anxiety
☐ Other Health Information_____
☐ Behavioral Concerns_____
☐ Concerns that might affect performance at school_____
☐ No Known Health Problems

☐ Any medications to be administered at school requires the completion of Authorization of Medication From signed by Doctor and Parent/Guardian.

List two emergency contacts (Family or friends to pick up children)
1.Name_____Phone #_____
2. Name_____Phone # _____

In case of accident of serious illness, and we are unable to be reached, I hereby authorize the school to call the physician listed and to follow his/her instructions. If the physician is unable to be contacted, the school may make whatever arrangements are deemed necessary.

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(Parent/Guardian) (Print Name) (Date)