HEALTH INFORMATION

Date: _____

Student Name: _____

Allergies (describe reaction and treatment used): _____

_____

Does your child have an epi-pen? Yes No

Chronic illness or conditions that may affect school performance (list any health conditions such as migraines, seizures, diabetes, hearing problems, ADHD, behavioral, etc.).

_____

Is your child currently taking any medications? (Please include medication taken at home or school, including inhalers)

Medication Dosage and Time Reason for taking medication

_____

_____

_____

Does your child wear glasses or contacts? Yes No All of the time Only for reading

Does your child have Asthma as diagnosed by a physician? Yes No

Do they have an inhaler at school with them? Yes No

Asthma triggers: _____

List and give dates of any serious injuries or surgeries within the last year: _____

_____

List any immunizations updates your child may have received within the last year (Name of immunization, date and place) _____

Other health concerns we should be aware of _____

Insurance: ____ Private (List name _____) ____Medicaid ____HAWK-I

____ No Insurance ____Other (List Name _____)

The above information may be shared with school personnel for provision of appropriate health and/or educational services.

IT SHOULD BE UNDERSTOOD THAT PROPER ATTENTION FOR THE CHILD IS OUR PRIMARY CONCERN. IN CASE OF EMERGENCY, YOUR CHILD WILL BE TRANSPORTED TO THE CLOSEST MEDICAL FACILITY AT THE PARENTS EXPENSE.

I AGREE TO THIS AND ALLOW THE PHYSICIAN TO TREAT MY CHILD.

Signature of Parent/Guardian: _____