STUDENT HEALTH INFORMATION 2011/12
(Parent/Guardian to complete both sides)

Below please check any chronic conditions that your child has, list medications taken and answer the related questions. This information may be shared by the school nurse with school staff as needed to best serve your child while at school.

Student Name:		Birth Date:
Homeroom Teacher:		Grade:

Chronic Condition	✓ If Yes	List Medications/Time	Describe
ADD/ADHD			
Allergies			To what? Type of reaction:
Arthritis			
Asthma			Date of last Episode: Known Triggers:
Autism/Asperger's Disease			
Cancer			Type: Under Treatment or in Remission Since:
Cerebral Palsy			Walking Aid:
Cystic Fibrosis			
Diabetes			Insulin via: Pump or Injection
Down's Syndrome			
Epilepsy/Seizures			Date of last Seizure:
Frequent Ear Infections			Tubes? Yes or No
Headaches/Migraines			How frequent? Triggers:
Hearing Problems			Hearing Aid Worn: Left Right Cochlear Implant: Yes No
Heart Condition			Specify:
Hemophilia			
High Blood Pressure			
Kidney or Bladder Problems			Specify:
Menstrual Problems			Specify:
Multiple Sclerosis			Walking Aid:
Muscular Dystrophy			Walking Aid:
Nosebleeds			Frequency:
Orthopedic Problems			Specify: Walking Aid:
Psychological Disorder			Specify:
Sickle Cell Disease			
Skin Problems/Eczema			Specify:
Spina Bifida			
Stomach Problems			Specify:
Vision Problems			Glasses or Contact lenses Worn Reading Only or For all School work
Other			

Will your child need to take medication during the school day ☐ **YES** ☐ **NO**

If **yes**, please see the medication policy in the parent handbook and contact your school nurse to request a medication

PLEASE COMPLETE THE REVERSE SIDE OF THIS FORM BEFORE RETURNING

STUDENT HEALTH INFORMATION 2011/12
(Parent/Guardian to complete both sides)

authorization form.

PLEASE COMPLETE THE REVERSE SIDE OF THIS FORM BEFORE RETURNING