

**STUDENT INFORMATION**

Name \_\_\_\_\_ DOB    /    /    Gender    M    F  
 School \_\_\_\_\_ Grade \_\_\_\_\_ Parent/Guardian Name \_\_\_\_\_  
 Phone # \_\_\_\_\_ Phone # \_\_\_\_\_ Email \_\_\_\_\_

**HEALTH HISTORY**

Check all conditions your child currently has or has been treated for in the past

CONDITION	EXPLAIN
Diabetes	
Seizures	
Allergies	
Asthma	
Lung/Respiratory Disease	
Heart/Cardiovascular Conditions	
Head Injury/Concussion	
Behavioral or Emotional Difficulties	
Neurological Disorders	
Attention Disorders (ADD,ADHD)	
Mental Health Conditions (e.g., anxiety, depression)	
Fainting Spells and Dizziness	
Kidney/Bladder Conditions	
Ear/Eyes/Nose/Sinus Problems	
Muscle or Bone Conditions	
Abdominal/Stomach/Digestive Problems	
Migraines or Severe Headaches	
Food Restrictions/Special Diet	
Skin Conditions	
Mobility Problems or Activity Restrictions	
Learning Problems	
VISION CONCERNS	Glasses/Contacts    Yes    No    For:
	Last professional eye exam    /    /    Results:
HEARING CONCERNS	Hearing Device    Yes    No    Type:
	Right    Left    Both ears
<b>List any other medical conditions:</b>	

**MEDICATIONS**

List all prescription, over-the-counter, and medications taken as needed (e.g., EpiPen, inhalers, pain relievers)

Medication	Dose	Frequency	Reason

Would you like to schedule a conference with the licensed school nurse to discuss a particular health concern?    Yes    No

Indicate your concern(s):

The information you provide will only be shared with school staff who require access to this information to meet your child's health and safety needs while at school. Not providing complete and accurate information may result in an incomplete health and safety plan for your child.

\_\_\_\_\_  
Parent/Guardian signature

\_\_\_\_\_  
Date