

Student Medical / Health Information

School Form

Please help us update our records by completing the following information. Please include ALL information, even if you have reported it before. All students must return this completed form to your homeroom teacher

by
PLEASE PRINT

Student's First and Last Name: _____ 2009-10 Grade: _____

Family E-mail: _____

Home Phone: _____ Mom Cell: _____ Dad Cell: _____

Address: _____

Date: _____

Does this student have allergies? (check those that apply)

- | | | |
|---|---|---------------------------------------|
| <input type="checkbox"/> No Allergies | <input type="checkbox"/> Seasonal Allergies | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Peanuts | <input type="checkbox"/> Animals: _____ | _____ |
| <input type="checkbox"/> Tree nuts | _____ | _____ |
| <input type="checkbox"/> Milk | _____ | _____ |
| <input type="checkbox"/> Other foods: _____ | <input type="checkbox"/> Medications: _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

If you answered "yes" to any of the above, describe treatment or anything we need to know about your child's reaction to this allergy. (ie, Epi Pen, Benadryl, Prescription, etc.)

Does this student have asthma?

- Yes
- No

If yes, please explain the treatment / procedures for school:

Does this student take daily medication during school hours?

Yes

No

If yes, give the details (medication name, time it is administered, what it is for): _____

Does this student have Diabetes?

Yes

No

If yes, have you provided the school up to date information about your child's needs. If you have not, please do so.

**Does this student have any other medical concerns/needs that we need to be made aware of
(Please do not assume that we know):**

Parent Signature: _____

Parent Signature: _____