Transportation: _____

SCHOOL HEALTH INFORMATION

Student #_____ Grade _____ Teacher/HR _____

Student _____, _____ Nickname: _____
Last Name First Name

Address _____ Gender: M F DOB ____/_____/_____

Health History

Allergies: Please list allergies and reaction to allergens:	**Usual Reaction**	**Life Threatening:**	
Example: nuts	Example: Breathing Difficulty	×Yes	□No
		□Yes	□No
		□Yes	□No
		□Yes	□No
		□Yes	□No

Diabetes	□Yes	□No
Sickle Cell Disease	□Yes	□No
Cancer	□Yes	□No
Physical Handicaps	□Yes	□No
Seizure Disorder	□Yes	□No
Asthma	□Yes	□No
ADHD/ADD	□Yes	□No
Other		
	_____	

If you answered *yes* to any of the above, please detail specifics in the space provided along with any other physical or mental health issues which may be a concern at school.

_____

_____

□ Does your child have any condition that would limit physical education activities? List _____

□ Does your child take any prescribed medication routinely? List _____

Do we have permission to complete Hearing and/or Vision Screenings on your child? □ Yes □ No

I hereby give permission for my student to receive: (CHECK all that apply) □Tylenol □Advil □Caladryl/Calamine Lotion □Benadryl Cream □cough drops ☐ Vaseline □Tums (or generic equivalent) according to label instructions.
A parent will be contacted prior to administration.

In the event of an emergency, if I cannot be reached, the school will have my child transported to the hospital via the EMS/911 service to receive appropriate treatment.

Emergency Contact Information

Parent 1 Name:_____Relation_____Phone_____

Parent 2 Name:_____Relation_____Phone_____

Other 1 Name:_____Relation_____Phone_____

Other 2 Name:_____Relation_____Phone_____

Parent Signature: _____ Date_____