STUDENT HEALTH INFORMATION 2024-2025

Must be Updated Yearly and Returned to the School Nurse

Student Name _____ Date of Birth _____ Grade _____

Physician/Clinic _____ Dentist _____

↳ Phone Number _____ ↳ Phone Number _____

Hospital Preference _____

To ensure the health and safety of your child, this information may be shared with school district staff or emergency personnel based on a need-to-know basis.

Health Concerns	**Yes**	**No**	**Medication (Name, dosage)**	**Necessary Monitoring in School**	**Comments or Describe**
Asthma/ Respiratory				Inhaler at school? Y N	
Severe Allergies				Food Latex	Type of reaction: Date of last reaction:
Diabetes					
Head Injury					
Seizures/ Neurological					Type and Date of last episode:
Heart/Blood					
Muscles/Bones/ Joint/Skin					
Bladder/Kidney					
Stomach/ Intestine/Bowels					
Immune Problems					
Emotional/ Behavioral					
Hearing Concerns				Hearing Aid? Preferential seating?	
Vision Concerns				Glasses or Contacts? Reading only?	
Growth/Nutrition Concerns				Dietary restrictions:	
Developmental Concerns					
Other Health Concerns					

If your child becomes ill or injured, the school will attempt to call the parent/guardian at home or at work. If you cannot be reached, the school will attempt to call the emergency contact. In case of serious accident/injury/illness, 911 will be called if necessary.

Signature: _____ Date: _____