(District Name Here)

Student Health Record

School____________________
Grade___ Homeroom__________

(Please complete: Information to be shared with teaching staff as needed.)

Male ☐ Female ☐

Student's Name:______________________ Date of Birth:____________ Age______

Address:______________________Home Ph.:__________Cell Ph.:__________

Father/Mother/Guardian:______________________Work Ph.:__________

Emergency Contact Person:______________(relationship)__________Phone:________

Social Security No.:__________ Medicaid No.:____________Health Ins.:__________

Student's Medical History

Problem	No	Yes	List symptoms and medicines needed...
Allergies to food			Name:
... to medication			Name:
... insect bites or stings			Name:
... other (including seasonal)			Name:
Asthma			
Attention deficit (ADD, ADHD)			
Birth defect/physical handicap			
Bone or joint problems			
Convulsions (seizure/epilepsy)			
Diabetes (high blood sugar)			
Earaches (frequent? tubes?)			
Emotional/Psychological disorder			
Headaches (frequent or takes medicine)			
Heart problem			
Hypertension (high blood pressure)			
Nose bleeds			
Sinus problems			
Speech and/or Hearing problems			
Stomach or digestive problems			
Surgery			
Vision (seeing) problems			Glasses? ___yes ___ no Contacts? ___yes ___no

Describe any handicaps or special needs of student:______________________

Student's Healthcare Providers:______________________Phone No.:__________
______________________ Phone No.:__________

Is the student taking daily medication? No☐ Yes☐ If yes, please name:______________

I give my permission for my child to participate in the school's health program which includes health education and basic screenings (vision, hearing, scoliosis, etc). I also give my permission for my child to receive standing orders/first aid care as needed.

I give my consent for pertinent medical information to be shared between the medical provider and the school nurse and/or school personnel directly involved with my child at school.

Parent/Guardian Signature:______________________**Date:**__________

Revised 05/08