ANNUAL STUDENT HEALTH DATA FORM
SCHOOL YEAR: __________

Student's Name: ____________________________________ Date of Birth: ___________________

Family Physician: ______________________________ Clinic Name/Number: ___________________

IT IS EXTREMELY IMPORTANT THAT WE HAVE ACCURATE AND UP-TO-DATE PHONE NUMBERS LISTED SO THAT WE MAY REACH YOU IN THE EVENT THAT YOUR CHILD BECOMES ILL OR EXPERIENCES A MEDICAL EMERGENCY.

Parent/Guardian Name: ______________________________________ Phone: ___________________

Emergency Contact Name: ____________________________________ Phone: ___________________

HISTORY/MEDICAL DIAGNOSES – please circle **YES** if your student had or currently has any of the following:

ADD/ADHD	Yes No	Heart/Blood Disease	Yes No
Asthma	Yes No	High Blood Pressure	Yes No
Bone/Muscle Condition	Yes No	Hearing Loss	Yes No
Chronic Ear/Throat Infections	Yes No	Frequent Nosebleeds	Yes No
Concussion/Head Injury	Yes No	Physical Disability	Yes No
Frequent Headaches/Migraine	Yes No	Urinary/Kidney Issues	Yes No
GI/Stomach/Bowel Issues	Yes No	Vision Problems	Yes No
Glasses/Contacts	Yes No	Other Health Concerns	Yes No
Dietary Restrictions	Yes No		

Please explain all **"YES"** answers: ____
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____
____

Please list and explain any **ALLERGIES** (food, medication, sting, seasonal,etc.):

ALLERGY	REACTION	TREATMENT

Please list all **DAILY** and **AS NEEDED** medications and reason (at home and/or at school):
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____
____

NOTE: **ALL prescription and over-the-counter medications (including inhalers and EpiPens) that may be needed during the school day and/or during after-school activities **MUST** have a written order from a licensed physician as well as a parent/guardian signature in order to be administered by the school nurse or designated school staff. Medications **MUST** be delivered to the school nurse by a parent/guardian.

NOTICE OF AGREEMENT

__ YES __ NO I hereby give permission for my child to participate in school-provided Vision, Hearing, Scoliosis and Dental screenings as available.

To ensure safe care of my child, I agree that pertinent health information may be shared with appropriate school staff, including transportation employees on a need-to-know basis. I agree to alert the school nurse of any change in medication or health status of my child. I will furnish the school with current phone numbers and address in case of emergency. The school nurse may contact the health care provider listed regarding any health concerns pertaining to my child.

I hereby give consent for my child to receive medical care during regular school hours and/or during school related activities for basic first aid and emergency care that will be provided as needed by school personnel.

I understand that in an emergency my child will be transported by ambulance. I authorize emergency personnel to carry out diagnostic and emergency care as deemed necessary. I understand the cost of the ambulance and medical care are solely my responsibility.
My hospital preference is: ____

I acknowledge and understand that the information I have provided is correct and also considered confidential. I give my permission for the school nurse to share this information on a need-to-know basis with school personnel who may be in direct contact with my child (i.e. classroom teachers, substitutes, paras, administrative staff, office staff, bus drivers, cafeteria staff, coaches, etc.)

____ ___________________

Signature of Parent/Legal Guardian Date