HEALTH INFORMATION FORM 2024-2025

Student's Name_____ _____Male _____Female
Last *First* *Middle*

Date of Birth_____/_____/_____ Age_____ Grade_____

Student's Address _____City_____State_____Zip_____

Mother's Name _____ Phone_____

Father's Name _____ Phone_____

Please note: A Medication Authorization Form must be completed for every medication that needs to be given at school.

ALLERGIES

_____ Yes _____ No

Type *(Food, Insects, Drugs, Seasonal, Other)*_____

Reaction_____

Currently prescribed medications and treatments

_____

_____ **Medication needs to be given at school**

ASTHMA

_____ Yes _____ No

Triggers_____

Symptoms_____

Currently prescribed medications and treatments

_____

_____ **Asthma Action Plan**

_____ **Medication needs to be given at school**

ADD/ADHD

_____ Yes _____ No

Currently prescribed medications and treatments

_____

_____ **Medication needs to be given at school**

Continued on reverse

OTHER HEALTH CONCERNS

Please check all that apply

_____ Bladder Problem
_____ Bleeding Problem
_____ Bowel Problem
_____ Cancer
_____ Cerebral Palsy
_____ Cystic Fibrosis
_____ Dental Problems
_____ Diabetes
_____ Head Injury
_____ Hearing Problem
_____ Heart Condition
_____ Muscle Problem
_____ Seizures
_____ Sickle Cell Disease
_____ Speech Problem
_____ Spinal Injury
_____ Surgery
_____ Vision Problems
_____ Other _____

Please explain _____

_____

_____

List all prescription, over-the-counter, and herbal medications your child takes regularly

_____

I, _____, **hereby authorize my child's health care provider and designated provider of health care in the school setting, including all school-sponsored activities (e.g. athletic programs, field trips, etc.) to discuss my child's health concerns and/or exchange information pertaining to this form.** *Any photocopy of this form carries the same authority as the original.*

_____ _____

Parent/Guardian Signature *Date*