HEALTH INFORMATION FORM 2021-2022

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*