



Student's Legal Name _____ Male/Female Birth Date _____ Grade _____

Home Phone _____ Work Phones: Mom _____ Dad _____ Cell(s) _____

Names of others in household _____

Doctor's Name _____ Dentist Name _____

Is your student covered by health insurance? Yes No

Approximate date of last medical visit (include sports physical, if applicable) _____

Medications

- List any medications and dose taken regularly _____

- Do any medicines need to be taken at school? List _____

Medical History/Conditions

- List any serious illnesses, accidents, hospitalizations or surgery (include age) _____

- Please list any medical concern(s) that your student has **now** or had in the **past**:

Condition	Now	Past	Condition	Now	Past
Asthma or Reactive Airway Disease			Seizures type _____		
Attention Deficit Disorder (ADD or ADHD)			Skin Conditions		
Bronchitis/Pneumonia			Speech Problems		
Chickenpox			Stomach Problems		
Diabetes			Tooth Disease		
Frequent headaches (≥ 2 per week) or diagnosed migraines			Other (Circle or list) (Examples: heart, blood disorder, cancer, uncorrectable vision, etc)		
Mental Health Concerns					
Emotional or behavioral concern MD/Counselor Name: _____					
Head Injury			ALLERGIES: (PLEASE LIST) e.g. medication, food, insect bites. List allergies and required care:		
Hearing Loss/Frequent Ear Infections/Tubes in Ears (Circle)					
Heart Problems					
Neurological					
Nosebleeds					
Orthopedic/Bone Muscle Problems					

EXPLAIN ANY YES ANSWERS OR DESCRIBE ANY NEW HEALTH INFORMATION ON THE BACK

Prenatal History

Length of Pregnancy: _____ Full term? Or Premature Birth? Birth Weight: _____

Complications during pregnancy? _____

Substance use during pregnancy: Alcohol ___ Smoking ___ Medications ___ Recreational Drugs ___

Complications during birth (mom or baby)? _____

Age of mother at birth: _____ Age of father at birth _____

Early Infancy Developmental History Indicate age when student:

Sat _____ Crawled _____ Walked _____ Talked _____ Toilet Trained _____

Additional Comments/Concerns:

Miscellaneous Health Information

Does your student have a health condition that impacts his educational success, requires special equipment, therapy, or assistance? If yes, please describe: _____

Does your child wear glasses or contacts? YES NO Date of last eye exam: _____

Does your student have a 504 Plan? YES NO

Does the student have a family history of drug/alcohol substance abuse? YES NO

Does the student have a family history of learning disabilities? YES NO

Additional Information/Health Concerns of Parent

Permission for Health Advisory/Need to Know

School nurses develop a Student Health Advisory List each school year. All information is considered confidential and is shared only on a need-to-know basis.

I give permission to inform teachers and necessary staff about my child's identified health concerns. This permission shall be continuously in effect unless terminated by written notice from myself to the school in which my student is enrolled.

HEALTH CONDITION(S)

(PLEASE CIRCLE): ASTHMA, DIABETES, ADHD, OR OTHER (PLEASE LIST):

Date _____ Relationship to Student _____

Signature _____ Print Name _____