SCHOOL HEALTH OFFICE 2025 - 2026

STUDENT HEALTH FORM

DISCLOSURE:

HEALTH SCREENINGS: *THE AMERICAN ACADEMY OF PEDIATRICS RECOMMENDS CHILDREN RECEIVE A PHYSICAL EXAMINATION ANNUALLY. HEALTH INFORMATION IS VITAL IN PLANNING AND SUPPORTING STUDENTS WHILE ATTENDING SCHOOL.* ***MEDICATIONS:*** *WRITTEN CONSENT IS REQUIRED BY BOTH THE STUDENT'S GUARDIAN AND THEIR HEALTH CARE PROVIDER PRIOR TO ADMINISTERING ANY MEDICATION IN SCHOOL. PLEASE REQUEST A FORM FOR ANY PRESCRIOTION OR NON-PRESCRIPTION MEDICATION TO BE ADMINISTERED DURING SCHOOL HOURS.*

STUDENT INFORMATION

STUDENT NAME: _____ **BIRTHDATE:** __/__/__/____ **GENDER:**_____ **GRADE (2024-25)** _____

HEALTH CONCERNS

PLEASE **CHECK** THE FOLLOWING BOXES IF THE STUDENT HAS **ANY** OF THE FOLLOWING.
AN EMERGENCY PLAN & MEDICATION FORM WILL BE REQUIRED TO SUBMIT BY A DOCTOR FOR ANY CHECKED CONDITIONS.

NO HEALTH CONCERNS

☐ **NO HEALTH CONCERNS**

ALLERGIES GENERAL

☐ **ALLERGIES TO:** _____ **ALLERGY REACTION:** _____

CAUSED BY (CHECK APPLICABLE):

☐ INGESTION (EATING ALLERGEN) ☐ CONTACT (TOUCHING ALLERGEN) ☐ AIRBORNE (BREATHING ALLERGEN)

MEDICATION (EPINEPHRINE) WILL BE SUBMITTED FOR USE IN SCHOOL AS NEEDED (CHECK ONE): ☐ YES ☐ NO

FOOD ALLERGIES

☐ **FOOD INTOLERANCE TO:** _____ **ALLERGY REACTION:** _____

OTHER MEDICAL CONDITIONS

☐ **ASTHMA**

CAUSED BY (CHECK APPLICABLE):

☐ EXERCISE ☐ IRRITANTS (SMOKE, FRAGRANCES, ETC) ☐ ALLERGENS (POLLEN, MOLD, DANDER, ETC)

MEDICATION (ALBUTEROL)) WILL BE SUBMITTED FOR USE IN SCHOOL AS NEEDED (CHECK ONE): ☐ Yes ☐ No

☐ **DIABETES** **CHECK ONE:** ☐ **TYPE 1** ☐ **TYPE 2**

MANAGED BY (CHECK ONE): ☐ DIET/ACTIVITY ☐ ORAL MEDICATION ☐ INSULIN INJECTIONS ☐ PUMP

☐ **SEIZURES** **DESCRIBE TYPE/DESCRIPTION/FREQUENCY:** _____

☐ **BEHAVIORAL/MENTAL HEALTH CONCERN:** _____

☐ **RECENT SURGERY/RESTRICTIONS (LIST):** _____

☐ **OTHER HEALTH CONCERNS:** _____

MEDICAL INFORMATION

CLINIC AND DOCTOR: _____

HEALTH INSURANCE: _____

PREFERRED HOSPITAL IN THE EVENT OF AN EMERGENCY: _____

EMERGENCY CONTACT INFORMATION:

EMERGENCY CONTACT 1 NAME: _____ **EMERGENCY CONTACT 1 PHONE:** _____

EMERGENCY CONTACT 2 NAME: _____ **EMERGENCY CONTACT 2 PHONE:** _____

CONSENT

I ATTEST THE INFORMATION PROVIDED IS TRUE & ACKNOWLEDGE THAT IT IS MY RESPONSIBILITY TO INFORM THE SCHOOL OF ANY CHANGES TO THE HEALTH STATUS OF THIS STUDENT INCLUDING HEALTH CONDITIONS, NEEDS, MEDICATIONS, &/OR ALLERGIES. I UNDERSTAND & AGREE THAT THIS STUDENT MAY RECEIVE ROUTINE SCREENING FOR VISION & HEARING DEFICIENCIES. I WILL COMPLY WITH ALL SCHOOL ILLNESS, IMMUNIZATION, & MEDICATION POLICIES. I GIVE CONSENT FOR ANY NECESSARY MEDICAL TREATMENT &, TRANSFER OF THE STUDENT BY EMERGENCY MEDICAL SERVICES. THE CONTACTS LISTED BELOW HAVE MY PERMISSION TO PICK-UP THE STUDENT IF I AM UNAVAILABLE. FURTHERMORE, I GIVE PERMISSION FOR SCHOOL HEALTH STAFF TO CONFIDENTIALLY EXCHANGE HEALTH INFORMATION WITHIN THE SCHOOL OR WITH OUTSIDE HEALTH CARE PROVIDERS FOR USE IN MEETING THIS STUDENT'S HEALTH & EDUCATIONAL NEEDS IN SCHOOL.

PARENT/GUARDIAN PRINTED NAME: _____

PARENT/GUARDIAN SIGNATURE: _____

DATE: _____