HEALTH SURVEY / INFORMATION:

This information must be updated annually to ensure our records are current.

Student Name: DOB: Grade:

YES ☑	NO ☑	
		Severe reaction to insect stings? If yes, cause, reaction and treatment:
		Food allergies? If yes, cause, reaction and treatment:
		Other allergies? If yes, cause, reaction and treatment:
		*Epi-pen at School: ☐ In school Health Office ☐ With Student (requires Physician and parent Signature)
		Asthma? If yes, check one: ☐ Mild ☐ Moderate ☐ Severe Cause & Reaction:
		*Inhaler at School: ☐ In school Health Office ☐ With Student (requires physician and parent signature)
		Heart Condition? If yes, treatments and/or restrictions:
		Vision loss? (not corrected by glasses) If yes, describe:
		Hearing loss? If yes, describe: Hearing Aid(s):
		Emotional problems? (i.e. ADD, ADHD, depression, anxiety) If yes, describe:
		Diabetes? If yes, describe: Insulin Pump: CGM:
		Seizures? If yes, describe: Treatment:
		Migraines / Headaches? If yes, describe: Treatment:
		Physical limitations? If yes, describe:
		Student takes medication at home? If yes, list medication(s):
		Student will take medication at school? If yes, list medication(s):
		Medication Name:
		Medication Name:
		Any new immunizations received? If yes, complete with date:
		• Varicella: _____ • Tdap: _____ • Td: _____ • Other: _____

***Students who require prescription or over the counter medication during school hours must have a current medication consent form completed and signed by their parent/guardian and/or medical practitioner**. Students who have asthma, seizures, diabetes, or severe allergic reaction are recommended to fill out an action plan and signed by parent/guardian and/or medical practitioner. This form must be submitted to the office **prior to** medication being administered or taken at school. Medication must come in the original container and be appropriately labeled. **Forms can be found on the district website or in the school office**.

Additional Pertinent Medical Information:

The parent/guardian signature below allows the school to share student health concern information with school staff members, bus drivers, and coaches/advisors that may come in contact with the student.

Signature: Date: