HEALTH SURVEY / INFORMATION MUST BE COMPLETED BEFORE SCHOOL STARTS:

This information must be updated yearly to ensure our records are current. Read through all information and sign at the bottom.

Student Name:	DOB:	Grade:

YES (✔)	NO (✔)	
☐	☐	Student has had the Chicken Pox disease? If yes, approximate date:
☐	☐	Severe reaction to insect stings? If yes, cause & reaction:
☐	☐	Food allergies? If yes, cause & reaction:
☐	☐	Other allergies? If yes, cause & reaction:
☐	☐	*Epi-pen at School: ☐ In school Health Office ☐ With Student
☐	☐	Asthma? If yes, check one: ☐ Mild ☐ Moderate ☐ Severe Cause & Reaction:
☐	☐	*Inhaler at School: ☐ In school Health Office ☐ With Student
☐	☐	Heart Condition? If yes, describe:
☐	☐	Vision loss? (not corrected by glasses) If yes, describe:
☐	☐	Hearing loss? If yes, describe:
☐	☐	Emotional problems? If yes, describe:
☐	☐	Diabetes? If yes, describe:
☐	☐	Seizures? If yes, describe:
☐	☐	Migraines / Headaches? If yes, describe:
☐	☐	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: _____
☐	☐	NONE – No Health Concerns

***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: