

# HEALTH INFORMATION FORM (one form per child)

Student's Name \_\_\_\_\_ Teacher \_\_\_\_\_

Primary Phone Number \_\_\_\_\_  
(for emergency or sick child)

Does your child have any chronic health conditions? Yes / No			
Y / N	Condition	Y / N	Condition
	Asthma		Hemophilia
	Attention Deficit		Heart Problems
	Diabetes		Other:
	Depression		Other:
Please describe the status of your child's condition.			
Does your child's health condition require any emergency medication? Yes / No If so, please describe.			

Please list any medications your child takes on a regular basis.				
Name of Medication	Dosage	Frequency	Taken at Home	Taken at School

List any allergies your child has, including food, insects, etc.

Does the student wear / use any of the following:			
Y / N	Item	Y / N	Item
	Glasses		Hearing Aides
	Contacts		Orthopedic Braces
	Wheelchair		Other:

Has a physician placed any restrictions on your child's activities? Yes / No If so, please describe:

Is there any other health information that school staff should know about your child?

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_