EVERY PUPIL, EVERY FALL FORM

School Year: ____________________

STUDENT NAME: ________________________ DATE: ____________ BIRTH DATE: __________ GRADE: _________

Health Review

Breathing problems	**Heart problems**	**Neurologic problems**	**Eating problems**	**Gland problems**
__ Asthma	__ Heart surgery	__ Frequent headaches	__ Stomach problems	__ Diabetes
__ Reactive airway	__ Heart murmur	__ ADHD/ADD	__ Bowel problems	__ Kidney problems
__ Other problems	__ Other problems	__ Seizure disorder	__ Special diet at school	__ Thyroid problems

Doctor Ordered Special Need: __ Contacts/Glasses __ Hearing aids __ Seat close to instruction __ PE limitations

List Your Child's Allergies: **Food** ________________ **Medicine** ________________

Environmental ____________ **Insect** ____________ **Other** ____________

List any illnesses, operations or accidents your child has had this past year: ____________________

List any emotional, social or other conditions that might affect your child's school performance: ____________________

List other health concerns you would like the nurse/teacher to know about ____________________

Current Medications: ____________________ Medication to be given at school: ____________________

Emergency Information: Doctor Name: ____________________ Phone: ____________________
Hospital preference: ____________________

Parent information: Mother: ________________ Home: ____________ Work: ____________
Family E-mail ________________ Cell: ____________
Father: ________________ Home: ____________ Work: ____________
Cell: ____________

Is your child covered by insurance? Yes/No Carrier Name: ____________________

I give permission to the school nurse to share educationally relevant health and emergency information (to include medical diagnosis) with school staff on a need to know basis.
Parent Signature: ____________________ Date: ____________