

EVERY PUPIL EVERY FALL

SCHOOL YEAR: _____ **GRADE** _____

STUDENT NAME: _____ **BIRTHDAY:** _____

****Please place an "X" next to any/all health concerns relating to your child****

****Please list any TREATMENTS/MEDICATIONS that you use to treat your child's condition in the space provided****

- | | |
|--|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Stomach Problems _____ |
| <input type="checkbox"/> Inhaler needed at SCHOOL | <input type="checkbox"/> Bowel Problems _____ |
| <input type="checkbox"/> Frequent Headaches _____ | <input type="checkbox"/> Special Diet at School _____ |
| <input type="checkbox"/> ADHD/ADD _____ | <input type="checkbox"/> Diabetes _____ |
| <input type="checkbox"/> Seizure Disorder _____ | <input type="checkbox"/> Kidney Problems _____ |
| <input type="checkbox"/> Anxiety _____ | <input type="checkbox"/> Thyroid Problems _____ |
| <input type="checkbox"/> Heart Murmur/Conditions _____ | |

Does your child need: Contacts/Glasses Hearing Aids PE limitations Seat Close to Instruction

Allergies:

Food: _____ Insect: _____
Medicine: _____ Other: _____
Environmental: _____ **EPI-Pen available at school**

Current Medications your child is taking: _____

List any emotional, social or other conditions that might affect your child at school: _____

List any other health concerns you would like the nurse/teacher to know about: _____

List any operations, accidents or hospitalizations your child has had in the past year: _____

Is your child covered by Insurance? YES NO Carrier Name: _____

In the event of an emergency what is your hospital preference? _____

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:** _____