Student Health Services

20___ - 20___

The school health service is concerned with helping parents provide the best care possible for their children. Help us achieve this goal by furnishing the following information for your children's health record.

Student's Name: _____ Date of Birth ___-___-_____

Social Security Number: _____ Grade _____

PLEASE INDICATE IF YOUR CHILD HAS OR EVER HAD THE FOLLOWING, IF SO, PLEASE EXPLAIN.

1. Emotional problems? _____
2. Learning Disability? _____
3. Attention Deficit Disorder/Hyperactivity_____
   Medication used?_____ When and where given? _____ How often? _____
4. Speech problems (indicate specific problem, e.g., stuttering, lisp, etc.) _____
   If yes, is your child being treated? Explain where, by whom and what time? _____
   _____
5. Hearing Impaired? If yes, does your child have a hearing aide, ear tubes, receive medication, etc.? _____
   _____
6. Visually Impaired? If yes, does your child wear glasses, contacts, have sty's, etc.? _____
   _____

PLEASE CIRCLE ANY OF THE FOLLOWING THAT YOUR CHLD HAS OR HAS HAD:

(If yes, please explain in detail, send medical information and see the office for additional forms.)

1. Allergies (drugs, food, environment)
2. Asthma
3. Diabetes
4. Bone Disorders
5. Heart or Cardiac Disease
6. Kidney Disease
7. Rheumatic Fever
8. Tuberculosis
9. Sickle Cell Anemia
10. Significant weight loss or gain
11. Seizures
12. Frequent dizziness
13. Fainting
14. Convulsions
15. Other _____

Explanations: _____
_____

SPECIFIC SYMPTOMS WE SHOULD KNOW ABOUT such as minor complaints:

Please explain, in detail, what procedures to take should they occur during school hours.

1. Frequent Headaches
2. Sore Throats
3. Frequent Stomachaches
4. Hives
5. Nosebleeds
6. Frequent colds
7. Migraines
8. Other _____

Explanations: _____
_____

MEDICAL INFORMATION

Please answer all the following questions:

Doctor's name_____ Office # _____ Emergency # _____

Insurance Carrier _____ Group Policy # _____

Hospital preference (EMS or other consideration will override parent preference) _____

Any limits of Physical Activity (If yes, send paperwork) _____ Why _____

Is student under physician's care _____ For what condition? _____

Medication taken or as needed (name, dosage, & frequency) _____
_____

I have made the school aware of all pre-existing and current health problems, illnesses, diseases and/or injuries my child has had or has at the present.

Parent/Guardian signature: _____ Date: _____