Student Health Information

(To be completed by parent/guardian)

Student Name:_____ **DOB:**_____

Grade:_____ **School:** _____

Please provide the following medical information for the school nurse.

Student's medical conditions / concerns (please describe):

_____

_____

_____

_____

Does your child have any of the following (please describe):

Vision or Hearing concerns: _____

ADD/ADHD:_____

Asthma:_____

Seizures:_____

Depression:_____

Diabetes:_____

Daily medications (please list names and doses):

_____

_____

Please list your child's allergies, reactions and treatments:

_____

_____

MEDICAL CONSENT: I give consent to the school nurse to share health information with appropriate school personnel as needed, to exchange information with my child's primary care physician, and to provide first aid as needed.

Parent/Guardian Signature:_____ **Date:**_____