

HEALTH SURVEY/INFORMATION: This information must be updated annually to ensure our records are current.

| | | |
|----------------------|-------------|---------------|
| Student Name: | DOB: | Grade: |
|----------------------|-------------|---------------|

| YES (✓) | NO (✓) | |
|--------------------------|--------------------------|----------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Student has had the chicken pox disease. Approximate Date: |
| <input type="checkbox"/> | <input type="checkbox"/> | Severe reaction to insect stings. Cause/Reaction: |
| <input type="checkbox"/> | <input type="checkbox"/> | Food allergies. Cause/Reaction: |
| <input type="checkbox"/> | <input type="checkbox"/> | Other allergies. Cause/Reaction: |
| <input type="checkbox"/> | <input type="checkbox"/> | * Epi-pen at school: <input type="checkbox"/> In School Health Office <input type="checkbox"/> With Student |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma (check one): <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe Cause/Reaction: |
| <input type="checkbox"/> | <input type="checkbox"/> | * Inhaler at school: <input type="checkbox"/> In School Health Office <input type="checkbox"/> With Student |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart condition (describe): |
| <input type="checkbox"/> | <input type="checkbox"/> | Vision loss (not corrected by glasses): |
| <input type="checkbox"/> | <input type="checkbox"/> | Hearing loss (describe): |
| <input type="checkbox"/> | <input type="checkbox"/> | Emotional problems (describe): |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes (describe): |
| <input type="checkbox"/> | <input type="checkbox"/> | Seizures (describe): |
| <input type="checkbox"/> | <input type="checkbox"/> | Migraines/Headaches (describe): |
| <input type="checkbox"/> | <input type="checkbox"/> | Physical limitations (please list): |
| <input type="checkbox"/> | <input type="checkbox"/> | Student is taking medication at home that the school needs to be aware of: List Medication: |

*Please list any medications the student will be taking at school:

Location of medication: In School Health Office With Student

Please complete with date any new immunization boosters the student has received:

Varicella (chicken pox) _____ Tdap _____ Td _____ Other _____

***Students who require prescription or over the counter medication during school hours must have a current medication consent form completed and signed by their parent/guardian and/or medical practitioner.** This form must be submitted to the office **prior to** medication being administered or taken at school. Medication must come in the original container and be appropriately labeled. **Forms can be found in the student handbook, on the district website, or in the school office.**

Additional Pertinent Medical Information:

The parent/guardian signature below allows the school to share student health concern information with school staff members, bus drivers and coaches/advisors that may come in contact with the student.

Signature: _____ **Date:** _____