

**HEALTH INFORMATION FORM  
2011-12**

Student's Name \_\_\_\_\_ Teacher \_\_\_\_\_  
Physician Name and Address \_\_\_\_\_

**Does your child have any chronic health conditions? Yes / No**

Y / N	Condition	Y / N	Condition
	Asthma		Hemophilia
	Attention Deficit		Heart Problems
	Diabetes		Other:
	Depression		Other:

Please describe the status of your child's condition.

Does your child's health condition require any emergency medication? Yes / No  
If so, please describe.

**Please list any medications your child takes on a regular basis.**

Name of Medication	Dosage	Frequency	Taken at Home	Taken at School

**List any allergies your child has, including food, insects, etc.**

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**Does the student wear / use any of the following:**

Y / N	Item	Y / N	Item
	Glasses		Hearing Aides
	Contacts		Orthopedic Braces
	Wheelchair		Other:

**Has a physician placed any restrictions on your child's activities? Yes / No**

If so, please describe:

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**Is there any other health information that school staff should know about your child?**

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I give permission for pertinent health information to be shared with school staff and by child's bus driver as needed. Yes \_\_\_\_\_ No \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

RETURN FORM TO SCHOOL AS SOON AS POSSIBLE