

**HEALTH INFORMATION FORM
2009-2010**

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