Student Health History

Student Name_____
Legal Last Name First Name Middle Name

Does your child have any of the following medical conditions? Please circle yes (Y) or no (N) for each condition.

Y N	ADD or ADHD	**Y N**	Epilepsy/Seizures
Y N	Allergic to bee stings ___Mild ___Moderate ___Severe	**Y N**	Heart Condition
Y N	Appendicitis	**Y N**	Migraine Headaches
Y N	Asthma ___Mild ___Moderate ___Severe	**Y N**	Rheumatic Fever
Y N	Chicken Pox Month____ Year____	**Y N**	Other
Y N	Diabetes		

If any yes answers, please explain_____
_____
Please list any known allergies_____
Is your child on any medications at home? If yes, please list_____
Is your child currently under a doctor's care? If yes, please give reason_____

Occasionally your child may need acetaminophen or a cough drop at school. Please check yes or no:
☐Yes ☐No My child may be given an age-appropriate dose of acetaminophen (Tylenol) at school.
☐Yes ☐No My child may be given a cough drop at school.

Family Doctor_____ Insurance_____

EMERGENCY CONTACTS (other than parent)

Name	Relationship	Phone Number

Emergency Contacts - Parental approval for the student to be picked up from school, for any reason, by someone other than the parent/guardian **must be given**. The school will not release the student to any one not listed on this form.

If emergency medical action or treatment is required and a parent/guardian cannot be contacted, I hereby consent for my student to be given medical care and if necessary, transported by ambulance to the hospital or doctor's office.

_____
Parent/Guardian Signature Date

SIBLINGS LIVING IN THE HOME

Name	School Attending