EAST ALTON #13 SCHOOL HEALTH SERVICES
Student Health Information

Your child's learning depends on good health. To assist us in providing health services at school, please complete the following form and return to your school nurse. **This information may be shared with staff as appropriate for the well being of your child.**

Student Name: ______________________________
Date of Birth: ______________________________
Gender: __________ **Grade:** __________ **Teacher:** __________

Physician's name: __________ **Physician's phone** __________
Date of last physical exam: ______________________________

Allergies to food, drugs, insects, etc? YES NO
Please list: ______________________________
Reaction to allergy: ______________________________
Has the allergy required emergency action in the past year? YES NO
Comments: ______________________________
Is the allergy considered life-threatening? YES NO
Comments: ______________________________

Does your child have asthma? YES NO Treatment: __________
Asthma triggered by: ______________________________

Does your child have diabetes? YES NO Date diagnosed: __________
Does your child take insulin? YES NO

Does your child have epilepsy/seizures? YES NO Type: __________
Is your child under doctor's care for seizures? YES NO Date of last seizure: __________
Medication: __________

Does your child have a heart condition? YES NO Describe: __________

Does your child have any Physical restrictions? YES NO Explain: __________

Circle any of the following health concerns that pertain to your child:
Eyes: Glasses/contacts: Reading/Distance Crossed Lazy Eye
Ears: Tubes Frequent infections Hearing difficulty Hearing aid: Left Right
Other: Nosebleeds Eating Sleeping Bladder/Bowels Headaches
Blood disorder Phobias ADD/ADHD Blood pressure Skin conditions
Dental Requires diapering Requires Catheterization
Please explain any of the above circled: ______________________________
____

Daily medication at home? YES NO
Name of medication and reason for taking: ______________________________
____
List serious illness or injuries: ______________________________
List any surgeries(operations): ______________________________
Other health concerns: ______________________________

Signature of Parent/Guardian: ____________________ **Date**: __________
Reviewed by Nurse: YES NO Nurse signature: __________