Student Name: _____ Date of Birth: _____ Grade: _____

AOS92
STUDENT HEALTH INFORMATION

Child's Primary Care Physician: _____ Phone Number: _____

Child's Primary Care Dentist: _____ Phone Number: _____

Health Insurance Provider: _____ Insurance Certificate No.: _____

If in an emergency that your child needs to be transported to a hospital and a parent/guardian cannot be reached, is there a preferred hospital? Yes _____ No ____

If Yes, Preferred Hospital Name: _____

Is there any reason that your child would not be able to participate in any or all school activities? Yes ____ No ____

If yes, Please explain: _____

AUTHORIZATION FOR RELEASE OF INFORMATION

I, the parent/guardian of the above named child consent to communication and exchange of health information between the school nurse and my child's licensed health care provider regarding immunizations, physical exams, medications and current health status. Yes ____ No ____

Parent/Guardian Signature: _____ Date: _____

IF ANY INFORMATION ON THIS FORM CHANGES DURING THE SCHOOL YEAR, PLEASE NOTIFY SCHOOL NURSE IMMEDIATELY.

HEALTH CONDITIONS

Please indicate any serious illness and/or allergies that school or emergency personnel need to be aware of in the spaces provided below (i.e. Diabetes, Asthma, Bee Sting, Allergies, etc.).

Accident (broken bone, head injury, major accident, etc.)
Please explain: _____ Date: _____

Food Allergies
Life Threatening Epi Pen: Yes ____ No ____
Allergy to: _____ Reaction: _____
Non Life Threatening
Allergy to: _____ Reaction: _____

Medication Allergy
Life Threatening Epi Pen: Yes ____ No ____
Allergy to: _____ Reaction: _____

Non Life Threatening
Allergy to: _____ Reaction: _____

Other Allergy (Bee Sting, etc)
Life Threatening Epi Pen: Yes ____ No ____
Allergy to: _____ Reaction: _____

Non Life Threatening
Allergy to: _____ Reaction: _____

Latex Allergy Yes ____ No ____

Asthma Inhaler: Yes ____ No _____ Type: _____

ADHD Yes ____ No ____ Medication: _____

Bleeding Disorder/Hemophilia Yes ____ No ____

Chicken Pox Date of Disease: _____

Diabetes ** If Yes, see the School Nurse
Insulin Yes ____ No ____
Pump Yes ____ No ____

Hearing Problem
Repeated Ear Infection Yes ____ No ____
Hearing Aid Yes ____ No ____

Speech Problem Type: _____

Vision Problem Glasses: Yes ____ No ____ Contacts: Yes ____ No ____

Heart Condition Type: _____

Pneumonia Date: _____

Past Surgery Type: _____

Other Health Concerns or Issues: