NEW SCHOOL STUDENT HEALTH INFORMATION
(EACH SCHOOL YEAR, this Form MUST BE COMPLETED AND SIGNED BY A PARENT OR GUARDIAN)

PART 1 – Must be completed for all students.

Student's Last Name:	Student's First Name:	Student's Middle Name:
Student's Date of Birth: (mm/dd/yyyy)		Student's Grade Level:
Home Phone: ( )	Mother/Guardian Cell Phone: ( )	Father/Guardian Cell Phone: ( )

For All Students: If there are NO medical or health conditions that affect your student's school day, please sign and return this form to the school. Do not complete Parts 2 and 3.

_____ _____

Parent or Guardian Signature: *Date:*

***Only* For Returning Students**:

Check the box below, only if all previously submitted medical and/or health conditions that affect your student's school day remain unchanged. Please sign and return this form to the school. Do not complete Parts 2 and 3.

MY STUDENT'S HEALTH INFORMATION REMAINS UNCHANGED & DOES NOT REQUIRE UPDATING. √ here [ ]

_____ _____

Parent or Guardian Signature: *Date:*

If there are medical and/or health conditions that affect your student's school day, please complete Part 2 & Part 3.

PART 2 - (Please √ all applicable conditions and provide information)

☐ Allergies ☐ Foods ☐ Bee Sting/Insect ☐ Other_____	☐ Hemophilia ☐ Physical Disability (be specific) _____ _____
☐ Heart Problems (be specific) _____	☐ Asthma ☐ Tuberculosis (TB) ☐ Respiratory (be specific)_____
☐ Cancer (be specific)_____ _____	☐ Seizures (be specific) _____ _____
☐ Diabetes (be specific) _____ _____ _____	☐ Vision Problems (be specific) _____ _____ ☐ Glasses ☐ Contacts
☐ Hearing Problems (be specific) _____ ☐ Hearing Aids	☐ Other (be specific) _____ _____

How does this condition affect your student's school day? (i.e. P.E. restrictions/limitations, avoid certain foods, etc.)

_____

What does your student do to manage this condition during his/her school day? _____

_____

Please list specific symptoms with which your student presents when experiencing an episode of his/her condition. How long do symptoms last? _____

_____

Does your student require any special procedures during his/her school day? (i.e. use of nebulizer, glucometer, catheter, epi pen, etc.) _____ If yes, please obtain forms from your student's physician and consult with school personnel as soon as

possible. Is medication required during school hours? _____ If yes, submit forms from the physician with specific instructions for administering the medication(s) at school.

PART 3 - (Please √ all applicable conditions and provide information)

If your student has ALLERGIES, ASTHMA, DIABETERS or a SEIZURE DISORDER, complete the appropriate section below. Parent must transport medication to and from school.

A. ALLERGIES (check all appropriate symptoms and reactions)

☐ Coughing ☐ Difficulty breathing ☐ Food (be specific) _____	☐ Generalized swelling ☐ Hives ☐ Insect stings/bites (be specific)_____	☐ Local swelling ☐ Nausea ☐ Rash ☐ Weakness	☐ Wheezing ☐ Weakness ☐ Other_____ _____

B. ASTHMA (check all symptoms and reactions)

Triggers: ☐ Food _____ ☐ Exercise _____ ☐ Environmental factors _____	☐ Chest tightness/discomfort/pain ☐ Coughing ☐ Difficulty breathing ☐ Hoarseness	☐ Throat feels itchy/tight/sore ☐ Wheezing ☐ Other _____ _____

Please check all appropriate and currently prescribed treatments and/or management plans.

☐ Inhaler(s) ☐ Nebulizer	☐ Oral antihistamine(s) ☐ Oral bronchodilator(s)	☐ Oral steroid(s) ☐ Peak flow monitoring

Has the student been hospitalized? Please describe:

C. SEIZURE DISORDER | Type of seizure: | Does an aura occur prior to onset?

Behavior during a seizure:

Age at onset:	Date of last seizure:	Average length of seizure:

List medications:

D. DIABETES | Is your student insulin dependent? Yes ( ) No ( )

If yes, indicate: Types: Times: Dosage:

Is it necessary for your student to receive insulin during the school day? Yes ( ) No ( ) If yes, submit forms from the physician with type, dosage, and time of administration.

Symptoms of insulin reaction:

Treatment for insulin reaction:

Will a glucometer be used in school? Yes ( ) No ( ) If yes, please contact school personnel and submit the physician's usage instruction form with type, dosage, and time of administration.

Does your student require special scheduling of lunch/P.E./snacks? Yes ( ) No ( ) If yes, please contact school personnel.

Parents and guardians must complete the required forms and are responsible for providing the school with any medication, snacks/juices, and medical equipment that your student will require during the school day.

_____ _____

Signature of Parent #1 or Guardian #1 **Date**

_____

Above, clearly print the name of Parent #1 or Guardian #1: (first name, last name)

_____ _____

Signature of Parent #2 or Guardian #2 **Date**

_____

Above, clearly print the name of Parent #2 or Guardian #2: (first name, last name)