

*Dear Parent/Guardian: Please complete the information below for your child's health record. This information is strictly confidential and allows the nursing staff to ensure the health safety of your child. If an emergency does arise and your child needs to be sent to the hospital, a copy of this form may accompany them. It is important that the information is complete and up-to-date. Thank you for filling out this form. Please return the completed form to the school nurse.*

Student's Name: \_\_\_\_\_ Grade/Teacher: \_\_\_\_\_ Birth Date: \_\_\_\_\_

*Please indicate if your child has had or now has any of the following:*

	YES	NO
Chicken Pox.....	<input type="checkbox"/>	<input type="checkbox"/>
TB Exposure .....	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes .....	<input type="checkbox"/>	<input type="checkbox"/>
Asthma .....	<input type="checkbox"/>	<input type="checkbox"/>
name of inhaler: _____		
Blood Disorder.....	<input type="checkbox"/>	<input type="checkbox"/>
Serious Injury .....	<input type="checkbox"/>	<input type="checkbox"/>
describe: _____		
Birth Defect.....	<input type="checkbox"/>	<input type="checkbox"/>
describe: _____		
Allergies.....	<input type="checkbox"/>	<input type="checkbox"/>
food: _____ medications: _____ bee sting: _____		
History of head injury.....	<input type="checkbox"/>	<input type="checkbox"/>
Eye/Vision Defect.....	<input type="checkbox"/>	<input type="checkbox"/>
Ear/Hearing Defect.....	<input type="checkbox"/>	<input type="checkbox"/>
Heart Defect.....	<input type="checkbox"/>	<input type="checkbox"/>
Seizures .....	<input type="checkbox"/>	<input type="checkbox"/>
Bone/Joint Disorder .....	<input type="checkbox"/>	<input type="checkbox"/>
Developmental Delay .....	<input type="checkbox"/>	<input type="checkbox"/>
Hospitalization .....	<input type="checkbox"/>	<input type="checkbox"/>
describe: _____		
Surgery .....	<input type="checkbox"/>	<input type="checkbox"/>
describe: _____		
Medications .....	<input type="checkbox"/>	<input type="checkbox"/>
list current medications and dosage: _____		

*From the "yes" answers above, please describe in detail:* \_\_\_\_\_

List other health concerns not listed above: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Hospital Preference: \_\_\_\_\_

I, \_\_\_\_\_, give permission for the school nurse to treat my child if/when an emergency arises and to provide the necessary information to school personnel and emergency personnel.

Parent/Guardian Signature \_\_\_\_\_ Phone Number \_\_\_\_\_ Date \_\_\_\_\_