Student Health History

Student's Legal Name _____ _____ _____
Last First Middle

Health Record

Does your child have, or has your child had, any of the following medical conditions? Please circle **(Y)** yes or **(N)** no. Explain any yes answers.

Y N	ADD or ADHD
Y N	Allergic to bee stings: __ mild __ moderate __ severe
Y N	Asthma: __ mild __ moderate __ severe
Y N	Chicken Pox: Month ___ Year ___
Y N	Diabetes
Y N	Epilepsy/Seizures
Y N	Gastrointestinal (stomach) disorders
Y N	Heart Condition
Y N	Migraine headaches
Y N	Psychiatric Problems
Y N	Skin disorders
Y N	Urinary Conditions

Please list any known allergies: _____
Is your child taking any (prescribed or over-the-counter) medications or supplements at home? If yes, please list: _____
_____
Is your child currently under a doctor's care? If yes, please explain: _____

Family Doctor: _____ Health Insurance: _____

Parental Permissions

Occasionally, your child may need acetaminophen (tylenol) or a cough drop at school Please check **Yes** or **No**:

Yes __ No __ My child may be given an age-appropriate dose of acetaminophen at school.
Yes __ No __ My child may be given a cough drop at school.

Emergency Contacts

Parental approval must be given for a student to be picked up from school for any reason by someone other than the parent/guardian. The school will not release the student to anyone not listed below:

Name	Relationship	Phone Number

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: _____