Student Confidential Health Form

Student Full Name: School Name:

Grade: Date of Birth:

Please check below any conditions affecting your child which may affect their welfare in school.

- ☐ Drug Allergy
- ☐ Food Allergy
- ☐ Insect Allergy
- ☐ Environmental Allergy
- ☐ ADHD
- ☐ Diabetes
- ☐ Asthma
- ☐ Arthritis
- ☐ Heart Condition
- ☐ Concussion
- ☐ Kidney Disease
- ☐ Hearing / Vision Problems
- ☐ Seizure Disorders
- ☐ Recent Injuries
- ☐ Recent Surgeries

List and explain, any items checked above and any illnesses, injuries, or health problems the child has had in the past year or is currently being treated for:

List the medications your child takes on a regular basis:

	Name of Drug	Reason
1.		
2.		
3.		
4.		

My child wears: ☐ Glasses ☐ Contact Lenses ☐ Hearing Aid(s) ☐ Other Prosthesis

Name of Health Care Provider: ______________________ Phone: ______________

Name of Dentist: ______________________ Phone: ______________

Permission for emergency medical treatment in case of injury or illness and parent/guardian is not available:

1. In an emergency, the information on this form may be given to emergency medical personnel ☐ **Yes** ☐ **No**
2. I permit medical personnel to treat my child ☐ **Yes** ☐ **No**
3. If my child must be hospitalized, my hospital preference is:

____

Print Name of Parent/ Guardian: ______________________________

Parent/ Guardian Signature: ______________________ **Date:** ______________