HEALTH INFORMATION FORM
2014-15

Student's Name _____ Teacher _____

Phone number for emergencies_____

Does your child have any chronic health conditions? Yes / No			
Y / N	**Condition**	**Y / N**	**Condition**
	Asthma		Hemophilia
	Attention Deficit		Heart Problems
	Diabetes		Other:
	Depression		Other:
Please describe the status of your child's condition.			
Does your child's health condition require any emergency medication? Yes / No If so, please describe.			

Please list any medications your child takes on a regular basis.				
Name of Medication	**Dosage**	**Frequency**	**Taken at Home**	**Taken at School**

List any allergies your child has, including food, insects, etc.

Does the student wear / use any of the following:			
Y / N	**Item**	**Y / N**	**Item**
	Glasses		Hearing Aides
	Contacts		Orthopedic Braces
	Wheelchair		Other:

Has a physician placed any restrictions on your child's activities? Yes / No **If so, please describe:**

Is there any other health information that school staff should know about your child?

Parent/Guardian Signature _____ Date _____