



STUDENT HEALTH INFORMATION School Year: _____

Student name: _____ Birth Date: _____ School: _____ Grade: _____

HEALTH CONCERNS	YES	NO	MEDICATION (name/dosage)	RESTRICTIONS/ MEDICAL EQUIPMENT	DESCRIPTION/COMMENTS
Asthma/Respiratory					
Severe Allergies				Foods, Latex, Insects, Nuts, Medications?	Type of Reaction: Date of last Reaction:
Diabetes				Equipment: Pump:	
Head Injury					Date of injury:
Seizures/Neurological Conditions/Migraines					Type of last episode: Date of last episode
Heart /Blood Conditions					
Muscle/Joint/Bone					
Skin Conditions					
Bladder/Kidney					
Stomach/Intestines					
Immune Conditions					
Hearing/Ear Concerns					
Vision/Eye Concerns					
Growth/Developmental Concerns					
Emotional/Behavioral/ Attention Concerns					
Accidents/Injuries					
Other Health Concerns					

If your child needs to take medication while at school, please provide a "Provider Medication Authorization" form filled out by your child's medical provider. If your child has asthma, diabetes, severe allergies or seizures, please go to the Elizabeth School District Health page for the required forms.

Parent/Guardian Signature

Contact Phone #

Date

Please contact the District Nurse if you would like to discuss any of the above information (303-646-6730)