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 "Permission to Give Prescription Medication at School" form filled out by your child's physician. 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)