SCHOOL HEALTH OFFICE

2026-2027

STUDENT HEALTH FORM

Student's Name _____ **Birthdate** ___ / ___ / ___ **Gender** ____ **Grade (2026-27)** _____

The American Academy of Pediatrics recommends children receive a physical examination annually. Health information is vital in planning and supporting students while attending school. Please provide us with current health information each school year.

HEALTH CONCERNS: Please **X** if the student has any of the following. **Submit Emergency Plan + Medication Form for* conditions.***

_____ **NO HEALTH CONCERNS**

_____ **Allergies*** to _____;reaction_____

Caused by (circle): Ingestion (eating allergen) Contact (touching allergen) Airborne (breathing allergen)

Medication (epinephrine) will be submitted to be used, as needed, in school (circle): Yes No

_____ Food Intolerance to _____; reaction_____

_____ **Asthma*** _____

Caused by (circle): Exercise Irritants (smoke, fragrances, etc) Allergens (pollen, mold, dander, etc)

Medication (albuterol) will be submitted to be used, as needed, in school (circle): Yes No

_____ **Diabetes*** (circle): Type Type 2 Managed by (circle): Diet/Activity Oral medication Insulin injections Pump

_____ **Seizures*** type/description/frequency _____

_____ Behavioral/Mental Health Concern _____

_____ Recent Surgery/Restrictions _____

_____ Other Health Concern _____

Clinic and Doctor _____

Health Insurance _____

Preferred Hospital in the event of an emergency _____

MEDICATIONS: Complete a Medication Form for ***any*** medication (both prescription and non-prescription) needing to be administered during school hours (forms available upon request). WRITTEN CONSENT IS REQUIRED BY BOTH THE STUDENT'S GUARDIAN AND THEIR HEALTH CARE PROVIDER prior to administering any medication in school.

CONSENT: *I attest to the information provided. I acknowledge that it is my responsibility to inform the school of any changes to the health status of this student including health conditions, needs, medications, and/or allergies. I understand and agree that this student may receive a routine screening for vision and hearing deficiencies. I will comply with all school illness, immunization, and medication policies. In the event of an emergency, I give my consent for medical treatment deemed necessary and, if necessary, the transfer of the student by Emergency Medical Services. The contacts listed below have my permission to pick-up the student if I am unavailable. Furthermore, I give permission for school health staff to confidentially exchange health information - both within the school as well as with outside health care providers - for use in meeting this student's health and educational needs in school.*

_____ _____ _____

Parent/Guardian Printed Name **Parent/Guardian Signature** **Date**

_____ _____

Phone Number(s) **Email**

_____ _____

Emergency Contact 1 Name **Phone Number**

_____ _____

Emergency Contact 2 Name **Phone Number**