STUDENT HEALTH FORM

STUDENT NAME _____ GRADE _____

PRIMARY CARE PHYSICIAN _____ PHONE # _____

DENTIST _____ PHONE # _____

MEDICAL INSURANCE: (circle) YES / NO (circle) PRIVATE / MO HealthNet

MEDICAL INFORMATION: DOES YOUR CHILD CURRENTLY HAVE ANY OF THE FOLLOWING? (CIRCLE)

ASTHMA (USES INHALER)	BLEEDING DISORDER	ORGAN RECIPIENT
SEIZURE DISORDER	BOWEL / GI DISORDER	AUTISM
DIABETES TYPE 1 / TYPE 2	KIDNEY DISEASE / BLADDER DISORDER	DEPRESSION
CHRONIC INFECTION	HEART DISEASE (ACTIVITY RESTRICTIONS)	ADD/ADHD
VISUAL IMPAIRMENT	ORTHOPEDIC DISABILITY	ANXIETY / OCD
HEARING IMPAIRMENT	MIGRAINE HEADACHES	ODD
CHRONIC SKIN CONDITION	FREQUENT NOSEBLEEDS	PTSD

Other Condition(s): _____

Explanation: _____

Medication Needed At School? Y / N Medication: _____

DO YOU BELIEVE YOUR CHILD HAS A DISABILITY THAT SUBSTANTIALLY LIMITS A MAJOR LIFE ACTIVITY? Y / N

If yes, please explain: _____

ALLERGIES / EPI-PEN REQUIRED?

__Food Allergies (list) _____

__Medication Allergies (list) _____

__Wasp/Bee Sting Allergy _____

__Other Allergies (list) _____

__**Requires Epi-Pen** (Parent to bring prescription labeled Epi-Pen & fill out medication form)

EMERGENCY MEDICATION INFORMATION

My child **CANNOT** receive epinephrine (Epi-Pen) even when trained school personnel believe he/she is having a life-threatening anaphylactic reaction.

My child **CANNOT** receive Albuterol (quick acting asthma inhaler) even when trained school personnel believe he/she is having a life-threatening reaction.

Parent/Guardian Signature: _____ **Date:** _____

(Revised 03/22/21)