ANNUAL STUDENT HEALTH FORM

To be completed by parent/guardian **and** submitted with immunization record

Student Name and DOB:_____

Primary Care Provider:_____ #_____

Dentist:_____ #_____

Specialist:_____ #_____

History/Medical Diagnosis: (Check all that apply)

□ Allergies (food/medication/insect/latex)_____

□ History of Anaphylaxis: Epi Pen □ Allergy Action Plan □

□ Asthma: Albuterol Inhaler □ Asthma Action Plan □

□ Diabetes: Type I □ Type II □ Diabetes Management Plan □

□ Seizure Disorder: Seizure Action Plan □

□ Emotional/Behavioral Health (specify)_____

□ Developmental Delay □ Genetic Disorder □ Heart or Lung Condition

□ Hearing or Vision Concerns □ Glasses/Contacts □ Hearing Aide

□ Nutritional Needs □ Mobility Concerns

Other Health Concerns:_____
(Medical diagnosis that impact your child's health and safety during the school day may need additional health care plans. Please contact your school nurse.)

Medications: List prescription and over the counter medications given (home/school)

Medication:_____ Dose:_____ Frequency:_____

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Medication:_____ Dose:_____ Frequency:_____
(Medication administered at school requires additional forms, contact your school nurse.)

EMERGENCY PROCEDURE: In case of injury or illness requiring medical care, you have my permission to obtain such care from the nearest hospital* and to release personally identifiable information regarding my child. I agree to pay all expenses incurred in such emergency care.
*Preferred Hospital_____
Parent/Guardian Signature: _____Date:_____