Picture

Health Information Intake Form

Serious Medical Condition: _____

Student Name: _____ Date of Birth: _____ School: _____

Parent/Guardian: _____ Day Phone: _____ Cell: _____

Address: _____

(City) (State) (Zip)

Physician/Specialist_____ Clinic_____

Current medications given at home: _____

Details regarding your student's health condition and how it may affect their time at school:

_____

_____

_____

Other conditions staff should be aware of: (Check all that apply):

Vision Problem	Hearing Problem	Asthma
Diabetes	Heart Problems	Seizures

Life Threating Allergies, specify: _____

Comments (explain items checked above): _____

_____

_____

_____

More specific information may be gathered by the school health room. Contact with the office prior to the start of the school year would be greatly appreciated. If the student rides a bus, transportation department staff will be responsible for calling 911 if there is an emergency situation on the bus.

Parent/Guardian signature_____Date _____