Health Information
(*Please complete one form for each child attending school. Additional forms are available on the school website. ***)**

Please complete the following information to promote and protect the health of students.

Name of student: _____ **Grade**: _____ **School: _____**

Does this student have:

___Yes ___No **Asthma or bronchospasms**
___Yes ___No **ADD/ADHD/Behavioral issues**
___Yes ___No **Heart problems**
___Yes ___No **Blood pressure problems**
___Yes ___No **Kidney/urinary problems**
___Yes ___No **Hearing-Frequent Infections, Hearing Aids, or Tubes**
___Yes ___No **Diabetes**
___Yes ___No **Seizures**
___Yes ___No **Migraine headaches**
___Yes ___No **Depression/Anxiety**
___Yes ___No **Stomach/bowel problems**
___Yes ___No **Vision-Contacts/Glasses**

Other/Comments: _____

Medication	Dose	Frequency	Diagnosis	Given at school?
				___Y ___N
				___Y ___N
				___Y ___N
				___Y ___N
				___Y ___N

(If your student will be taking medication at school there is a separate form that needs to be filled out)

___Yes ___No Does your child have any allergies? If yes, to what are they allergic? (Examples: food, medication, environmental)_____ What is the reaction? _____
Do they use an epi pen? _____If yes, will you be providing one for the school? _____

___Yes ___No Has your child had any surgery, serious illness, or injury? Please explain.
_____

___Yes ___No Does or has your child had any other health or emotional concerns which you feel it would be helpful for the school to know? _____
_____

I give permission to school personnel to give my child topical antibiotic ointment, topical cortisone cream, topical antifungal cream, saline eye drops, lotion, contact solution, topical hydrogen peroxide, topical Caladryl clear lotion, glucose tablets, topical Vaseline when appropriate as needed.

I give my permission to the school nurse to share information relevant to my child's health condition with appropriate school personnel and NW AEA staff when needed to meet my child's health and safety needs. I give permission to the above named medical professionals to exchange information for the purpose of referral, diagnosis and treatment with the Le Mars Community School Nurse. I give specific permission to my health care provider to share any pertinent health information in my child's health record regarding: immunizations, administration of medications and/or educationally significant health information that may affect my child's learning and or safety at school.

_____ _____
Signature of parent/guardian Date