Health Information

Student Name: _____

ALLERGIES: Is your child allergic to any medications? Yes No

If yes, please list _____

Does your child have any other known allergies (food, nuts, insect stings etc.) *Yes No

If yes, please list _____ Epi Pen? Yes No

*** If your child does have severe allergic reaction, an "Allergy Action Plan" from your child's physician must accompany this form.**

ASTHMA: Does your child have asthma? *Yes No Inhaler? Yes No

***If your child does have asthma an "Asthma Action Plan" from your child's physician must accompany this form**

List any health conditions such as heart disease, diabetes, epilepsy, ear or eye problem, migraines or any chronic condition, etc.

_____
_____
_____
_____

List all medications your child is currently taking

Name	Dose	Time Given

Medications to be given at School.
(All medications must be given at home if possible)

Name	Dose	Time

List any other health considerations that your child may have (diet/exercise restrictions, activity restrictions, etc.).

_____
_____
_____
_____

Parent/Guardian Signature _____ Date _____