Health Record

Your child's learning depends upon good health. To assist in providing health services at school, please complete the following and return to the School Nurse.

Name_____Boy___Girl___Birthdate_____
Last First middle

Grade_____ **Teacher** _____

Parent/Guardian Home Phone #_____

Name_____Employer_____Wk#_____
Cell#_____
Name_____Employer_____Wk#_____
Cell#_____

Emergency Contacts

Name_____Relationship_____ Phone#_____

Name_____Relationship_____ Phone#_____

Check any Conditions that your Child has:

	ADD/ADHD		Diabetes		Head Injury
	Allergies:		Low Blood Sugar		Stomach Disorder
	Medictions		Anxiety Disorder		Seizures
	Food (peanuts, milk)		Depression		Frequent Headaches
	Seasonal		Hearing Problems		Other
	Other		Vision Problems		Other

Please explain any conditions checked from above:
_____
_____
_____
_____

Please list any medications your child takes at home or at school on a regular or as needed basis.

Medication	Dosage	Frequency	Reason

Please submit an updated immunization record for their Health File here at school.

Parent or Guardian signature_____ Date_____