Health Information

Student Name_____ Grade_____

Please check all that apply:

☐ ADD ☐ Current diagnosis ☐ History
☐ ADHD ☐ Medication Name:_____ ☐ At home ☐ At school

Allergies ☐ Current diagnosis ☐ History
☐ Medication Name:_____ ☐ At home ☐ At school
☐ Seasonal Allergies ☐ Tree nuts ☐ Penicillin ☐ Bee/wasp ☐ Eczema ☐ Peanuts
☐ Other nut allergies:_____
☐ Other Allergies_____

Asthma ☐ Current diagnosis ☐ History
☐ Medication Name:_____ ☐ At home ☐ At school
Triggers of Asthma: ☐ Mold ☐ Weather ☐ Pollen ☐ Smoke ☐ Dust ☐ Exercise ☐ Animals ☐ Viral infections
☐Other specify:_____

Diabetes ☐ Type 1 ☐ Type 2 ☐ Medication Name:_____
☐ Pump ☐ Pen ☐ Syringe

Heart Condition ☐ Current diagnosis ☐ History
☐ Tetralogy of Fallot ☐ Atrioventricular Septal Defect ☐ Atrial Septal Defect ☐ Aortic Valve Stenosis
Other not listed above:_____

Limitations or restrictions:_____

Joint disease ☐ Current diagnosis ☐ History
☐ Juvenile Arthritis ☐ Rheumatoid Arthritis ☐ Other specify:_____

Migraines ☐ Current diagnosis ☐ History
☐ Medication Name:_____ ☐ At home ☐ At school

Seizures ☐ Current diagnosis ☐ History
☐ Medication Name:_____ ☐ At home ☐ At school
☐ Generalized tonic-clonic ☐ Absence ☐ Partial ☐ Simple ☐ Complex
☐ Other not listed above:_____

☐ **Vision Concerns** ☐ **Hearing loss concerns** ☐ Right ☐ Left ☐ Both
☐ **Bladder Concerns** ☐ **Kidney concerns**
☐ **Skin Concerns**
Specify:_____
Limitations or restrictions:_____

Other:_____

Surgeries:_____

If your child will be taking daily and/or as needed medication at school a Medication Request form needs to be completed. They are available on the RFSD website—Health Services page or at the school health office. I hereby authorize the nurse, health aide, administrator, or other designated person to call any of the listed emergency contact if needed and provide first aid or basic health room care for my child.

Parent/Guardian Signature **Date**_____