DIXON UNIFIED SCHOOL DISTRICT
HEALTH INFORMATION

Grade: _____

ID# _____ Teacher: _____

Student's Name: _____Birthdate:_____/_____/_____
(Last) (First) (Middle Initial) (Month) (Day) (Year)

Health Insurance: ☐ Yes ☐ No **Type**: ☐ Medi-Cal ☐ HMO ☐ PPO ☐ POS

Company Name:_____ Group ID #: _____

Local Doctor:_____ Physician Phone Number: _____

Date of last physical exam: _____ Date of last dental exam:_____

Health information that may affect your child's safety and/or education will be given to staff responsible for his/her care.

No	Yes	Does your child **currently** have any of the following?
		Alergies: ☐ Pollen ☐ Insects ☐ Medications _____ ☐ Food _____ Epi-Pen prescribed: ☐ **Yes** ☐ No
		Asthma Inhaler prescribed: ☐ **Yes** ☐ No
		Back problems: Describe
		Diabetes: ☐ Type 1 ☐ Type 2
		Hearing Loss Hearing Aids ☐ Yes ☐ No
		Heart problems: Describe
		Joint Problems: Describe
		Migraine Headaches
		Seizures: Describe
		Skin Problems: Describe
		Vision Problems ☐ Glasses ☐ Contacts ☐ Color vision deficit
		Other:
		Operations or Accidents (Indicate type and dates):
		MEDICATIONS: According to the Education Code, parents are required to inform the school if their child is taking medication regularly. Name of Medications: _____ Supervising doctor:

Parent/Guardian: _____ Date: _____