HEALTH SERVICES

Name:______________________________________Grade: ___________.

DOB:______________________ Teacher: ___________________________.

Physician:__________________ Number:__________________________.

Check any Medical or Mental Health Conditions that have been diagnosed or is an ongoing problem for your child:

____ *Allergies (food/insect/medication)

____ *Asthma

____ *Uses inhaler/breathing machine

____ *Diabetes (type 1 or 2/ Hypoglycemia)

____ Hearing or speech Problem

____ Wears hearing aids

____ Vision Problems

____ Wears contacts/glasses

____ *Uses Epipen

____ *ADD/ADHD

____ Anemia/Bleeding Problem/Sickle Cell

____ Anxiety/Depression

____ Bladder/Bowel Problems

____ Cancer

____ Cystic Fibrosis

____ Dental Problems

____ Heart Conditions

____ Head Injuries

____ Headaches/Migraines

____ *Seizures

____ Hospitalizations/Surgeries

____ Stomach Problems

____ Tuberculosis

____ Other

(*) Additional forms need to be completed

Parent/Guardian Signature____________________________Number______________.