

EASTMONT SCHOOL DISTRICT STUDENT HEALTH INFORMATION

STUDENTS NAME _____ Grade _____

DOCTOR _____

Does your child have any of the following medical conditions?

_____ ADHD

_____ Asthma : Mild _____ Moderate _____ Severe _____ Treatment _____

_____ Bee Sting Allergy: Type of Reaction _____ Treatment _____

_____ Diabetes: Type _____ Treatment _____

_____ Food Allergy: Food _____ Type of Reaction _____ Treatment _____

_____ Heart Condition: Type _____ Treatment _____

_____ Seizure: Type _____ Treatment _____

Are there any other health problems or handicaps of which the school should be aware? Yes ___ No ___

If Yes, please specify: _____

Is there a condition that would limit PE/Recess/Field trip involvement? ___ In what ways? _____

Does your child have any medication allergies? Yes ___ No ___ Please list: _____

Does your child require any medications at home _____ at school _____

Name of medication: _____

If your child will need medications at school, additional forms will need to be signed by your physician and parent/guardian

I understand that the medical information provided above will be shared, when indicated, with those that need to know in order to provide a safe environment for my child.

If parents or emergency contacts cannot be reached in an emergency and treatment is urgent in the judgment of school authorities, school administrators may contact emergency medical services for transportation and treatment.

Parent/Guardian Signature _____ Date _____