



2020 - 2021 School Year Annual Health Information

Part A: Parent / guardian complete all of Part A and sign.

Student's Legal Name Last: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_

Birthdate: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Ethnicity: \_\_\_\_\_ Gender: \_\_\_\_\_ Grade: \_\_\_\_ Home Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Street Apartment # City State Zip Code

Parent or Guardian 1: Relationship to Student: \_\_\_\_\_
Last \_\_\_\_\_ First \_\_\_\_\_
Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_
Email: \_\_\_\_\_
Employed by: \_\_\_\_\_
Legal Guardian: \_\_\_ Yes \_\_\_ No Child Lives With: \_\_\_ Yes \_\_\_ No

1. Emergency Contact Name: \_\_\_\_\_ Cell # \_\_\_\_\_ Work # \_\_\_\_\_

2. Emergency Contact Name: \_\_\_\_\_ Cell # \_\_\_\_\_ Work # \_\_\_\_\_

HEALTH CONCERNS: Please X and explain if your child has any of the following (\* Submit an action plan for starred conditions.)

No health concerns
Allergies\* to \_\_\_\_\_; reaction \_\_\_\_\_
Food Intolerance to \_\_\_\_\_; reaction \_\_\_\_\_
Asthma\*: \_\_\_\_\_
Diabetes\*: [ ] Type 1 [ ] Type 2 [ ] Managed by: [ ] Diet/Activity [ ] Oral meds [ ] Insulin injections [ ] Pump
Seizures\*: type/description/frequency \_\_\_\_\_
Heart Condition \_\_\_\_\_
Concussion / Traumatic Brain Injury - date \_\_\_\_\_
Social/emotional/behavioral/mental health concerns \_\_\_\_\_
Recent surgeries, hospitalizations, injuries \_\_\_\_\_
Activity Restrictions \_\_\_\_\_
Implanted Devices \_\_\_\_\_
Bowel / Bladder Concerns \_\_\_\_\_
Other Health Concern \_\_\_\_\_
Health insurance (please name) \_\_\_\_\_
Medical Assistance prescriber # \_\_\_\_\_

Preferred Hospital in the event of an emergency \_\_\_\_\_

PROVIDER INFORMATION:

Table with 3 columns: Name, Location, Phone / Fax. Rows include Primary Health Care Provider, Specialist, and Dentist.

**Part A continued** Student's Legal Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Grade: \_\_\_\_\_

**MEDICATIONS:** List ALL medications including over the counter that this student takes, both at home and at school.

Medication Name	Dose	Purpose	How Often	Given during school?

**Guardian and Health Care Provider must complete a Medication Administration in School Form for any medication needing to be administered during school hours**

*I attest to the information provided on both pages. I acknowledge that it is my responsibility to inform the school of any changes to the health status of this student including health conditions, needs, medications, and/or allergies. I understand and agree that this student may receive a routine screening for any vision and hearing deficiencies. I will comply with all school illness and medication policies. Furthermore I give permission for school health staff to confidentially acquire & exchange health information - both within the school as well as with outside health care providers - for use in meeting this student's health and educational needs in school.*

\_\_\_\_\_  
 Parent/Guardian Printed Name (s)                      Parent/Guardian Signature                      Date

**Part B: To be completed by child's healthcare provider**

**Date of last physical exam:** \_\_\_\_\_ **Height** \_\_\_\_\_ **Weight** \_\_\_\_\_

Comments: \_\_\_\_\_

**Vision / Hearing**

Vision		Hearing	
Date of Last Exam		Date of Last Exam	
Exam Method		Exam Method	
Vision Impairment / Correction		Hearing Impairment / Correction	

**Please complete diagnosis / ICD-10-CM codes for all health conditions for this child**

Diagnosis	ICD-10-CM Code

Provider Name \_\_\_\_\_ Location \_\_\_\_\_

Provider Signature \_\_\_\_\_ Phone / Fax \_\_\_\_\_

Date \_\_\_\_\_