

STUDENT HEALTH INFORMATION

Provo City School District

Student's Name: _____ Sex: _____ Birth Date: _____ Grade: _____

Parent/Guardian: _____

Home Phone: _____ Cell Phone: _____ Email Address: _____

Student lives with: Both parents Mother Father Other _____

Healthcare Provider or Clinic Name: _____

MEDICAL HISTORY

The school nurse or health clerk may contact you for more information. Health information will be shared with school staff members on a "need to know" basis only. Please feel free to contact the school nurse at any time to update your student's health information.

- | YES | NO | Does your student have the following: |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Food or insect bite allergies (type and severity) _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma or other respiratory condition (type and severity) _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | ADD/ADHD/Autism (type and severity) _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Bone disease/deformity _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart condition or murmur (list any activity limitations) _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney condition/ disorder _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer/blood disorder _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Neuro/muscular disorder _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Skin condition _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Stomach/bowel condition _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy/Seizures (list type and frequency) _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Immune system disorder _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Mental health disorder _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Has your child had the Chickenpox disease? (if yes, what age) _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Serious accident or injury _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Had a vision exam? If yes, when was the last vision exam? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Wear glasses? If yes, what is the diagnosis?: _____ |

Any other health concerns that you would like the school nurse to know about? _____

MEDICATION

Does your student need to take any medications while at school? Yes No

If yes, what type(s) and reason: _____

*All medications (with the exception of asthma inhalers, epi-pens, and diabetes medications) must be kept in the office and administered by staff. A Medication Authorization Form signed by your healthcare provider is required before we can administer any medications. *Note: Students may have and self-administer asthma inhalers, epinephrine pens, and diabetes medications at school, however we need to have a form on file signed by your healthcare provider. These forms are available in the office and need to be updated each school year.*

Signature of Parent/Guardian

Date