

# Health Form

Please return this completed form to the office on or before Registration Day.

Student Name \_\_\_\_\_ Male  Female  Grade: JPK PK K 1 2 3 4 5

Pertinent Family History \_\_\_\_\_

## Current Health Issues

Y N

**Allergies:**  Food \_\_\_\_\_  Insect/Sting \_\_\_\_\_  Other \_\_\_\_\_

Type of allergic reaction:  Anaphylaxis  Local reaction  Other

Response required:  Benadryl  Epi-Pen JR.  Epi-Pen  Other  None

\*\*\*Please fill out a Food Allergy and Anaphylaxis Emergency Care Plan (FARE)\*\*\*

**Asthma:** Inhaler  Yes  No

\*\*\*Please fill out an Asthma Action Plan\*\*\*

**Seizures:** \_\_\_\_\_

**Diabetes:** Type I  Type II

**Special Diet:** \_\_\_\_\_

**Conditions identified that are important to schooling or physical activity** (heart issues, orthopedic concerns, vision problems, recent head injury, bleeding disorder, etc.)

Please specify: \_\_\_\_\_

**Restricted Activity**  Self-limiting  Physician request to limit \_\_\_\_\_

**Medication** to be taken and/or available at school.

\*\*\*Please fill out an Over-the-Counter and/or Prescription Medication form\*\*\*

**Other:** \_\_\_\_\_

*I authorize the school to obtain emergency medical care for my child in the event of illness or injury during school hours or during a school activity if I cannot be reached. I agree to bear the cost of any medical care provided for my child.*

This information is kept strictly confidential and will be shared with individuals caring for your child at school.

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_