Dear Parents, 9/11/2020

Medical History Form

If you could please complete the following form on the health history of your child, I would greatly appreciate it. I will be updated in your child's health history records as they are received to the Nurse's office.

Thank You,
Nurse Denise

Child's Name_____
Grade__**_____ Child's Homeroom**_____

Please check all that apply:

Asthma_____ Is an inhaler needed at school? Yes or No
Diabetes_____
Epilepsy or Seizure Disorder_____

Hearing Impairements_____ Is hearing aid required? Yes or No
Vision Impairements_____ Are glasses required? Yes or No

Any Allergies to food or medications? Yes or No
If so please provide allergies and reactions associated with them.
Does your child need an Epi-pen at school? Yes or No

Is your child on any daily medications that will need to be administered at school? Yes or No
If so please indicate the medication and the reason for administration.
Please provide a prescription from the physician as well as the original bottle medication was dispensed in and hand delivered to the Nurse's office.