

STUDENT HEALTH INFORMATION

St. Paul's Lutheran School

West Allis, Wisconsin

Student's Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Grade \_\_\_\_\_ School Year \_\_\_\_\_

**Please check here if your child has NO existing health conditions.**

Please list the appropriate health conditions your child has that the school should be aware of:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Sight Impairment                      Does child wear glasses? Y N

\*When prescription medications are to be given to your child at school, a medication consent form must be completed by your child's doctor, and medications need to be sent to school in their original container. For over the counter medications, a medication consent form must be completed by a parent/guardian and medications need to be sent to school in their original container.

\*When an Epi-pen and/or inhaler is/are required, a medication consent form must be completed by your child's doctor. Epi-pens and inhaler MAY be kept by the student during the school day if so desired.

No     Yes                      Does your child have severe or life-threatening allergies?

If yes, please list here: \_\_\_\_\_

Food Allergy: \_\_\_\_\_

Medication Allergy: \_\_\_\_\_

Insect (bite/sting) Allergy: \_\_\_\_\_

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

**Please read the statement below and sign.**

In order to make sure my child's special health needs are met, I allow my child's name to be shared confidentially with faculty and staff.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Cell Phone Number(s) \_\_\_\_\_