Confidential Confidential

STUDENT HEALTH INFORMATION
St. Paul's Lutheran School

Student's Last Name _____ First Name_____

Grade/Room #_____ School Year_____

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

Please check the appropriate box if your child's physician has diagnosed him/her with any of the following conditions:

- ❑ ADD or ADHD — Name of medication and dosage_____
- ❑ Arthritis
- ❑ Asthma — Does child carry an inhaler? Y N
- ❑ Bladder Problems
- ❑ Convulsive Seizures — Date of last seizure_____
- ❑ Deafness — Which ear?_____
- ❑ Diabetes — Test daily? Y N Give own shots? Y N
- ❑ Fractures — Where?_____
- ❑ Heart Condition — Is medication taken? Y N
- ❑ Internal Irregularities
- ❑ Kidney Problems
- ❑ Sight Impairment — Does child wear glasses? Y N
- ❑ Surgery in last 12 months: List:_____
- ❑ Physical Handicap
  Describe_____
- ❑ Other _____
- ❑ Takes prescription medications**
  List _____
  _____

**When medications are to be given to your child at school, a school permission form must be completed by your child's doctor and medications need to be sent to school in their original container.

- ❑ No ❑ Yes — Does your child have severe or life-threatening allergies? (If yes, please check the appropriate box(s) and list)
- ❑ Food Allergy:_____
- ❑ Medication Allergy:_____
- ❑ Insect (bite/sting) Allergy:_____
- ❑ Other:_____

- ❑ No ❑ Yes — Does your child have an Epi-pen?*

*When an Epi-pen is required a school medication permission form must be completed by your child's doctor and must send an Epi-pen to school.

If you have indicated a health condition above, please read the statement below and sign the bottom of this form.

In order to make sure my child's special health needs are met, I allow my child's name to be shared confidentially with professional and lay staff as determined by the school principal.

Parent's Signature_____ Date_____
Daytime Phone Number_____