

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 _____