STUDENT HEALTH INFORMATION

St. Paul's Lutheran School

Studen	t's Last Nam	e First Name
Grade/Room # S		School Year
	Please chec	k here if your child has NO existing health conditions.
followi	ADD or AD Arthritis Asthma Bladder Pro Convulsive Deafness Diabetes Fractures Heart Condi Internal Irre Kidney Prol Sight Impair Surgery in 1 Physical Ha Des Other Takes presc	Does child carry an inhaler? Y N blems Seizures Date of last seizure Which ear? Test daily? Y N Give own shots? Y N Where? Ition Is medication taken? Y N gularities blems rment Does child wear glasses? Y N ast 12 months: List:
		ns are to be given to your child at school, a school permission form must be completed or and medications need to be sent to school in their original container.
_ _	Food Allerg Medication Insect (bite/	Yes Does your child have severe or life-threatening allergies? (If yes, please check the appropriate box(s) and list) y: Allergy: sting) Allergy:
	No 📮	Yes Does your child have an Epi-pen?*
doctor	and must sen have indicat	is required a school medication permission form must be completed by your child's d an Epi-pen to school. ed a health condition above, please read the statement below and sign the bottom
In orde	er to make si	are my child's special health needs are met, I allow my child's name to be shared professional and lay staff as determined by the school principal.
Parent' Daytim	's Signature_ ne Phone Nur	Date