CONCORD COMMUNITY SCHOOLS
Student Medical/Health Information

The school nurse would like to know if your child has any diagnosed medical or health conditions that could affect him/her while at school. Disclosure of this information is optional, but helpful in the care and protection of your student.

Student's Name: _____ Grade: _____ Date of birth: _____

Medical Diagnosis

____ ADD/ADHD
____Bleeding Problem*
____Asthma*
____Epilepsy/Seizures*
____Diabetes*
____Heart Problem
____Digestive Problem
____Bee Sting Allergy*
____Scoliosis
____Other

Allergies

____Animals
____Dairy Products*
____Nuts*
____Peanut Butter*
____To Medication
____Diet Specification
____Other

Health Condition

____Nosebleeds
____Migraines
____Requires Glasses
____Requires Contacts
____Low Blood Sugar
____Requires Hearing Aid
____Bee Sting Sensitivity
____Skin Disorder
____Surgery/Procedures
____Other

***Please contact the school nurse to complete an Individualized Health Plan.**

Explain any checked areas above: _____

_____

List all medications student is on (include medications taken out of school time):

_____ _____
Medication, Dosage, Time — Reason

_____ _____
Medication, Dosage, Time — Reason

_____ _____
Medication, Dosage, Time — Reason

If taking medication at school, obtain a Medication Authorization form from the school office/clinic.

Family Physician _____ Phone number_____

Specialist_____ Phone number _____

Has this child had **chickenpox disease**? YES NO If yes, when? _____

I give permission for this information to be provided to the appropriate school personnel to best meet my student's health needs.

Parent/Guardian's Signature_____ **Date**_____

Phone number: (home) _____ **(cell)** _____