Annual Health Information Form 2019-2020

This is confidential information will be shared with school staff on a need-to-know basis.

Student Name: _____Grade: _____School: _____

Date of Birth: _____ Preferred Hospital:_____

Please check all CURRENT health conditions of your student:

ADD/ADHD ☐	Diabetes ☐	Developmental delay ☐	Migraines/headaches ☐
Allergies ☐	Bowel/bladder ☐	Head injury/concussion ☐	Seizure disorder ☐
Asthma ☐	Bone/joint ☐	Hearing loss ☐	Stomach issues ☐
Autism ☐	Depression ☐	Other:	

List any other **medical conditions** which may impact your student's learning at school, including dietary or physical restrictions:

Does your student currently take any **routine medications**? **Yes** ☐ **No** ☐ If Yes, list the medications your student takes:

Medication/Dose/Time:_____

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Will your student be taking any medications at school? **Yes** ☐ **No** ☐

****Please note: A physician order is required for **all** medications to be administered at school (including over-the-counter medications). Please contact school health office for more information.*

Does your student have any **ALLERGIES TO FOODS OR MEDICATION**? **Yes** ☐ **No** ☐

If YES, please list:_____

Does your student have a **Significant Life Threatening Allergy**? **Yes** ☐ **No** ☐

If Yes, list the specific allergy, reaction/symptoms and the month/year) of last reaction: _____

Will you be providing the school with rescue medication, such as Epinephrine, for the significant allergy? **Yes** ☐ **No** ☐

If rescue medication is **NOT** provided, **911** will be called if an emergency arises.

Does your student wear glasses/contacts? **Yes** ☐ **No** ☐ Vision Diagnosis:_____

Date of last vision exam by an eye doctor/eye specialist:_____

Does your child have **Medicaid**? ***Yes*** ☐ ***No*** ☐

*If your student does **NOT have health insurance**, please call Falcon Peak Health Center: **719-344-6247** for more information.*

Emergency Care Parent Permission: In case of serious illness or injury, first aid will be rendered in accordance with school policies. If ambulance service is necessary, the parent/guardian must assume financial responsibility.
If parent/guardian cannot be reached in the event of such emergency, your student will be sent to the preferred hospital listed above, or to the medical facility determined by Emergency Medical Service (EMS).

Student's Physician and phone number:

If needed, I (parent/guardian) give the school permission to contact my student's doctor to obtain **immunization records**.

Yes ☐ **No** ☐

Parent/Guardian Signature:_____

Emergency Contact: _____ **Emergency Contact Phone**: _____

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Parent/Guardian Signature:_____ **Date:** _____