

**It is important for the schools to have up-to-date health information on your child.
Thank you for updating it.**

**North Lake School
2023-2024
Health Information Form**

Student's Name: _____ Date of Birth: _____

Grade: _____ Teacher: _____ Homeroom: _____

The following information will help school personnel plan for your child's health needs. Information on this document may be made available to school, health care provider and health department authorities.

1. **No Medical Problems at this time**
2. Check medical problems or concerns below:
- | | | | | |
|--|---|--|---|-------------------------------|
| <input type="checkbox"/> Seizure Disorder | Date of last Seizure _____ | | | |
| <input type="checkbox"/> Bone/Joint Problems | <input type="checkbox"/> Frequent Nosebleeds | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> ADD | <input type="checkbox"/> ADHD |
| <input type="checkbox"/> Blood Disorders | <input type="checkbox"/> Past Concussions | <input type="checkbox"/> Vision Problems | <input type="checkbox"/> Glasses/Contacts | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hearing Difficulties | <input type="checkbox"/> Other (list specific concern) _____ | | |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Currently using an inhaler | <input type="checkbox"/> At Home | <input type="checkbox"/> At School | |
- List Allergies, if any: _____

Describe reaction: _____

Epipen prescribed? Yes No

Mental Health Condition Describe: _____

3. List medication taken: At Home _____
 At School _____
 Are back-up medications needed at school? _____

4. Special directions* (limitations or restrictions-physical/dietary, etc.)
 Food Allergy Restriction Note: If your child has a dietary restriction that is not self-managed (by parent/child), our food services department will need a medical note from the student's medical provider. This is a federal food services law.

5. History of any serious illness, injury, or surgery? _____

6. Check if your child has had:
- | | | | |
|--|------------|--|------------|
| Chicken Pox <input type="checkbox"/> | Year _____ | Premature Birth <input type="checkbox"/> | |
| Head Injury <input type="checkbox"/> | Year _____ | Hepatitis <input type="checkbox"/> | Year _____ |
| Immune Disorder <input type="checkbox"/> | Year _____ | Tuberculosis <input type="checkbox"/> | Year _____ |

Physician: _____ **Phone:** _____

IN THE EVENT OF A MEDICAL EMERGENCY, and after every reasonable effort has been made to contact parents/guardians, I authorize North Lake School District staff members, any qualified physician, or emergency medical personnel to transport my child to the nearest emergency treatment center so that reasonable and necessary medical care may be given.

I realize that the responsibility for all medical expenses incurred belong to the parents/guardian and will hold North Lake School District harmless.

Parent/Guardian Signature

Date