Health Card

Homeroom Teacher: _____

Grade: _____

Student Information

Name:		D.O.B.	
Address:			

Parent/ Guardian 1

Name:	
phone #:	
Email:	
Work phone #:	

Parent/ Guardian 2

Name:	
Phone #:	
Email:	
Work phone #:	

Primary Care Doctor

Doctor's name/Office:	
Phone number:	

Health Insurance: ☐Private ☐Medicaid ☐None **Support Plan in place?** ☐ 504 ☐IEP

Medical History – Diagnosed by a medical provider

Diagnosis	**Yes**	**No**	**If Yes, please explain…**
Vision difficulties			Wears glasses? ☐yes ☐no
Hearing difficulties			Uses hearing aid? ☐yes ☐no
Speech difficulties			
Allergies List all allergies:			☐food ☐environmental ☐seasonal ☐Other: _____ Prescribed Epi-Pen? ☐yes ☐no **Provide Allergy Action Plan and Epi-Pen to school nurse**
ADD/ADHD			
Asthma			**Provide inhaler and Asthma Action Plan to school nurse**
Autism			
Bleeding Disorder			
Cerebral Palsy			
Developmental Delay			
Diabetes			Insulin dependent? ☐yes ☐no **Provide Diabetes Care Plan to school nurse**
Feeding tube/ nutrition			
Heart Condition			
Lactose intolerant			**Provide doctor's note to school nurse for milk substitute**
Migraines			
Seizures			**Provide Emergency medication and Seizure Action Plan to school nurse**
Sickle Cell			
VP Shunt			
Other:			

Prescribed Medications

List medications:	

If medication can be given at home before or after school hours, please do so. **If your child has a medication that must be given during the school day, a medication administration form is required to be on file with the school nurse.** Prescription or OTC

Emergency Contacts that are authorized to pick up student

Name/ Relationship:	
Phone:	

Name/ Relationship:	
Phone:	

Name/ Relationship:	
Phone:	

Name/ Relationship:	
Phone:	

Note to Parent/ Guardian: This information will be kept confidential. In case of an emergency and you cannot be reached, the parent or guardian is responsible for any hospital, doctor or ambulance expense incurred in the best interest of your child. By signing this form your school nurse has permission to contact your medical provider as needed.

Parent/ Guardian signature: _____ Date: _____

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