

HEALTH ROOM FORM 2009-2010

CHILD'S NAME _____ GRADE _____ AGE _____ DOB _____

IMPORTANT: Please list contact names and phone numbers, in order of priority, should your child become ill during school hours and need to be picked up. Please label phone numbers as home, cell, work, etc.

1st Name: _____ Relationship to child: _____

Phone #'s: _____

2nd Name: _____ Relationship to child: _____

Phone #'s: _____

3rd Name: _____ Relationship to child: _____

Phone #'s: _____

- List any serious illness, injuries, or operations your child has/has had: _____

- Is your child under a physician's care for any reason? Yes No Please explain: _____

- Please check any of the following that apply to your child:

<input type="checkbox"/> ADD	<input type="checkbox"/> ADHD	<input type="checkbox"/> Asthma	<input type="checkbox"/> Depression	<input type="checkbox"/> Frequent nose bleeds
<input type="checkbox"/> Migraine	<input type="checkbox"/> Fainting	<input type="checkbox"/> Seizures	<input type="checkbox"/> Heart murmur	<input type="checkbox"/> Frequent Headaches
<input type="checkbox"/> Frequent trips to bathroom	<input type="checkbox"/> Bowel issues	<input type="checkbox"/> Severe menstrual cramps		
<input type="checkbox"/> Glasses	<input type="checkbox"/> Hearing difficulties	<input type="checkbox"/> Speech/language difficulties		

Other _____

- Does your child have any physical restrictions? Yes No If so, please explain: _____

- Does your child have seasonal allergies? Yes No Please list: _____

- Does your child have any allergies to food? Yes No Please list: _____

- Does your child have any allergies to medications? Yes No Please list: _____

- Is your child allergic to beestings? Yes No Is your child allergic to latex? Yes No

- **Does your child require an EpiPen for an allergic reaction? Yes No**

- Does your child take any medications (including an inhaler) at home? Yes No

Name of medication _____ Dose _____ Frequency _____

- Does your child require medication at school? Yes No

Name of medication _____ Dose _____ Frequency _____

- Dates of life stress events: Family relocation _____ Separation _____ Divorce _____

Parent remarriage _____ Parent illness _____ Death of family member/friend _____

Other _____

- Through the course of the 2007-2008 school year, can your child have any of the following? Please check all that apply. Non-medicated cough drops Cetaphil cream/lotion Petroleum jelly Braces Wax

Parent/Guardian Signature _____ Date _____