

JOINT SCHOOL DISTRICT NO. 2

DATE _____

STUDENT'S NAME _____

I AGREE THIS INFORMATION MAY BE SHARED WITH APPROPRIATE SCHOOL PERSONNEL FOR EDUCATIONAL OR SAFETY PURPOSES. PARENT/GUARDIAN SIGNATURE _____

PLEASE CHECK THE FOLLOWING HEALTH CONCERNS THAT APPLY:

- ALLERGIES:
 - Bee/insect sting: Call 911 if stung swells at site only other reaction _____
 - Medication _____ Reaction _____
 - Food _____ Reaction _____
 - Environmental _____ Reaction _____
- ASTHMA: What starts an attack? exercise colds allergies _____
 smoke other _____
 List asthma medications _____
- ATTENTION DEFICIT DISORDER: treatment _____
- BEHAVIORAL CONCERNS: treatment _____
- CHICKEN POX (VARICELLA): had shot had disease Date (mm/yy) _____
- EMOTIONAL CONCERNS: treatment _____
- DIABETES insulin dependent non-insulin dependent
- EATING/DIGESTION PROBLEMS _____
- KIDNEY/BLADDER PROBLEMS _____
- MUSCLE/JOINT/BONE PROBLEMS _____
- VISION: contacts glasses vision loss color blind other _____
 Date of Last Exam _____
- HEARING: hearing loss, describe _____
 frequent ear infections tubes in ears, which ear? _____ age _____
 speech therapy hearing aids
- HEADACHES/MIGRAINES: frequency _____ treatment _____
- HEAD INJURY: date _____ severity _____
- SEIZURES: type _____ frequency _____ medication _____
- PAST SURGERIES _____
- PAST MAJOR ILLNESS/INJURY _____
- MEDICATIONS: taken at home _____
 taken at school _____
- OTHER MEDICAL CONDITIONS OR LIMITING PHYSICAL DISORDERS _____

SIBLINGS LIVING AT HOME:

Name	Age	Grade	Name	Age	Grade
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____