HEALTH INFORMATION FORM

Student Name: ____ Grade: ___________

☐ My child does **NOT** have any known health condition.

☐ **ADD/ADHD** ___Takes Medication

☐ **Allergies** ☐ Has Epi Pen

- ☐ Bee Sting
- ☐ Food (list)_______________________
- ☐ Latex
- ☐ Medication (list)__________________
- ☐ Other Allergy____________________

☐ **Asthma**

- ☐ Inhaler at school: ___ In School Nurse Office ___With Student

☐ **Heart Condition (describe):____**

☐ **Diabetes** (Must provide School Management Plan from Dr.)

☐ **Seizures (describe):____**

☐ **Vision or Hearing Impairments:** ___Prescribed Glasses Last eye exam_______

☐ **Other Health Condition:** ____

MEDICATION: If your child requires medication during the school day, please complete a **School Medication Form** that is available in the school office. Prescription medication requires physician authorization.

Health Insurance: ___Private ___Medicaid/Badger Care __No Coverage

My signature gives permission to share this health information with the school district staff, school medical advisor, Trempealeau County Health Dept. and Wisconsin Immunization Registry working with my child. If in the judgment of school authorities, medical attention is necessary, I give permission for my child to be transported to the nearest emergency medical facility by ambulance, school vehicle, or privately owned vehicle. I agree to assume responsibility and expenses incurred in the handling of this emergency medical care.

______________________________ ______________________

Parent/Guardian Signature Date