

Yes	No	Condition	Details/Dates
		Migraine headaches	
		Nutritional/weight problem	
		Orthopedic problem (bone, joint)	
		Pregnancy	
		Rheumatoid Arthritis	
		Scoliosis/abnormal spinal curve: Date of diagnosis _____ Date of last evaluation _____	
		Seizure disorder, Type _____ Date of last seizure: _____ Meds: ___ Yes ___ No Medication _____ (Please provide physician documentation of diagnosis.)	
		Self-Harm/Mutilation	
		Sickle cell disease	
		Skin condition	
		Spina bifida	
		Substance abuse (alcohol, drugs, tobacco)	
		Suicide risk or attempt	
		Surgeries: _____	
		Thyroid disorder	
		Tics or twitches	
		Tourette's syndrome	
		Tuberculosis	
		Other	
Yes	No		
		My child is healthy and has no special health needs.	
Yes	No	HEARING	
		Hearing loss: [] Right - ___Mild ___ Moderate ___ Severe [] Left - ___Mild ___ Moderate ___ Severe	Hearing loss due to _____ Last evaluation _____
		Hearing aid [] Right [] Left	
Yes	No	VISION	
		Color deficiency	
		Legally blind	
		Vision problem/Eye defect _____ Last eye exam _____	
		Wears glasses [] All the time [] For distance only [] For reading only [] For sports	
		Wears contact lenses	

III. Medications: (Include prescription and over-the-counter medication)

Name _____ Used to Treat _____

MEDICATIONS IN SCHOOL: If your child has a medical condition that requires medication in school, a written physician's order is required. No medication may be carried in school or on a bus by a student; this applies to medications "over the counter" as well. There are several exceptions for students needing emergency medications whose order specifies that they may self-carry and self-administer their medication. All medication must be delivered to the school Health Office by the parent/guardian with the physician's order and written parental permission. Medication order forms are available through the Health Office and online.

IV. Additional Health Concerns:

Are there any other medical diagnoses or disabling conditions that might require a modification in your child's activities at school?
 Yes* No Specify: _____

* Any condition that would prevent full participation in educational programs (including physical education) requires physician documentation before modifications can be considered.

I understand that if my child's health status changes during the school year, I will provide the Health Office with updated information.

Parent/Guardian Signature _____ Date _____