STUDENT HEALTH REVIEW

Dear Parent/Guardian: Please complete this review regarding your student's health information. The information will be kept confidential and will be used by the school staff and the district nurse in order to understand your student's health needs and assist with educational planning. Please contact your student's teacher or the district registered nurse should you have further questions or concerns regarding your student's health information.
Thank You.

Teacher _____ **voice mail**_____

District Registered Nurse_____ **voice mail**_____

Student Name	**Birth Date**	**School and Grade**
Parent/Guardian	**Home Phone**	**Cell Phone**
Name of Student's Physician		**Physician Phone**

Significant Illness/Injury/Hospitalization:
Identified Health Concern(s) and Medical Diagnoses:

Please list the medications your student takes.

Medication	**Dose and Frequency**	**School**	**Home**

	Yes	**No**	**Describe**
Eyeglasses/Contacts/ Vision Concerns			
Hearing Aids/ Hearing Concerns			

Early Childhood Development	Describe
Complications at Birth	
Sitting, Crawling, Walking Alone	
Speech Development	
Balance and/or Coordination Issues	
Fine Motor Skills (handwriting, etc.)	

Student Health Concerns	YES	NO	Describe
Allergy (please list)			
Asthma/Respiratory			
Bowel/Bladder/Toileting Needs			
Diabetes			
Dietary Restrictions/Special Diet			
Social/Emotional/Mental Health (anxiety/depression)			
Heart/Blood			
Mobility Restrictions Muscle or Joint			
Neurological			
Seizures			
Significant Headaches			
Skin Disorders			
Head Injury			
Other			

Other Information Regarding your Student's Health Needs at School:

Parent Signature _____ ***Date***_____ _____