

BERESFORD SCHOOL DISTRICT HEALTH INFORMATION FORM

Student's name_____ Birthdate_____ Grade_____

Mom's name_____ Telephone_____

Dad's name_____ Telephone_____

Student's Physician_____ Telephone_____

List two people whom the school may contact if unable to reach you. Please include their phone number.

- 1)
- 2)

1. MEDICAL HISTORY- Has your child had any of the following MEDICAL PROBLEMS or INJURIES?

- | | | |
|---|--------|-------|
| 1. Surgery---type of surgery/dates of any surgeries | ___YES | ___NO |
| 2. Head Injury or concussion | ___YES | ___NO |
| 3. Nose Problems(frequent sinus infections, nose bleeds, etc | ___YES | ___NO |
| 4. Eye Problems(lazy eye, glasses, contact lens, etc) | ___YES | ___NO |
| 5. Hearing Problems(frequent ear infections, hearing aids, etc) | ___YES | ___NO |
| 6. Stomach Problems(IBS, constipation, reflux, diarrhea, etc) | ___YES | ___NO |
| 7. Skin Problems(rash, acne, dry skin, eczema, etc) | ___YES | ___NO |
| 8. Seizures(date of last seizure, what type of seizure) | ___YES | ___NO |
| 9. ADD/ADHD | ___YES | ___NO |
| 10. Asthma or any breathing problems | ___YES | ___NO |
| 11. Heart Problems(murmur, irreg. rhythm, birth defect,etc) | ___YES | ___NO |
| 12. Depression, anxiety or panic attacks | ___YES | ___NO |
| 13. Diabetes(diet-controlled, oral, insulin) | ___YES | ___NO |

If YES was marked please explain in the lines provided.

2. Does your child take any Prescription Medications? If yes please list name and when taken. Please include inhalers and/or nebulizers.

3. Does your child take any Over-the-Counter Medications on a regular basis?
Please list name and when taken.

4. Does your child have any allergic reactions from any of the following?(Check all that apply).

Seasonal or Environmental Allergies

Food Allergies(peanuts, milk, soy, wheat, eggs, dye, etc) Please List

Does your child have an epi-pen? NO YES if yes please bring one to school

Does your child have diet restrictions? NO YES if yes please explain below

Insect Allergies(bees, etc)

Does your child require Benadryl or other medication? _____

Medicine or shots

My child does not have any allergies that I am aware of

5. Details you feel necessary that should be known by the school:

Parent Signature _____ Date _____