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 below.

_____
_____
_____
_____
_____

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:

_____
_____

6. Vision screenings take place in grades K, 2, 4, 6,and 8. If you have a child in another grade would you like their vision screened? YES NO

7. Are you interested in receiving the results of your child's height and weight measurements taken throughout the school year? YES NO

Parent Signature_____Date_____