

**(Only complete if your child has a medical condition/allergy that the school should be aware of)**

**Student Health Information Form**

School: \_\_\_\_\_ Date: \_\_\_\_\_

Name of Student: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Signature: \_\_\_\_\_

Home Telephone #: \_\_\_\_\_ Work #: \_\_\_\_\_

Physician: \_\_\_\_\_ Telephone: \_\_\_\_\_

**To be completed by parent:**

Child's Name: \_\_\_\_\_ Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_

Medical Condition: \_\_\_\_\_

Symptoms:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Plan of Action: (Number in order of priority 1 being most important)  
Administer Medication \_\_\_ Call 911 \_\_\_ Call Parents \_\_\_  
Provide snack (if appropriate) \_\_\_ Other \_\_\_  
Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Thank you,

Carrie Meinert