

## Health Services Student Health Information

STUDENT: \_\_\_\_\_  M  F BIRTHDATE: \_\_\_\_\_  
 SCHOOL: \_\_\_\_\_ GRADE: \_\_\_\_\_

**PARENT/GUARDIAN:** Please **CIRCLE** the appropriate number(s) that best describes your student's current health condition(s) and return completed form to school. Please provide specific information regarding conditions that may affect student learning and participation in school activities.

**MEDICATION:** All medication (prescription, over-the-counter, homeopathic remedies, vitamins, etc.), which *is to be administered during the school day or during school-sponsored activities*, requires an Authorization for Medication Administration (H-26) to be completed and signed by physician and parent. Students are not allowed to carry medication without an Authorization to Carry Medication (H-26B) on file. Contact the Health Technician, even if you have already given this information to the band, flags, etc.

Number	Health Condition	Specific Information
009	ADD/ADHD	Medication: (032)
202	Allergy- <b>Serious</b> -Bee/Insect	Medication: (232)
203	Allergy- <b>Serious</b> -Food	Medication: (232)
204	Allergy- <b>Serious</b> -Medication	Medication (232)
205	Allergy- <b>Serious</b> -Other (animal, latex, etc.)	Medication: (232)
007	Asthma-Mild to Moderate	Medication: (032)
207	Asthma- <b>Serious</b>	Medication: (232)
022	Birth Defect/Genetic Disorder	Description:
227	Blood Disorders (Chronic)	
215	Diabetes – Insulin Dependent	
020	Emotional/Psychological/Eating Disorder	
023	Hearing Problems (infections, tubes, nerve damage, etc.)	
024	Deaf/Hard-of-Hearing	Right Ear <input type="checkbox"/> Left Ear <input type="checkbox"/>
025	Hearing Aids	Right Ear <input type="checkbox"/> Left Ear <input type="checkbox"/>
026	Heart Problems – No restrictions	
226	Heart Problems – Restrictions:	
032	Medication – Long Term	
033	Migraine Headache	Medication: (032)
042	Orthopedic Condition	Description:
046	Prosthesis	
045	Scoliosis	
237	Seizure Disorder – Type:	Medication: (032)
054	Visual Impairment	Right Eye <input type="checkbox"/> Left Eye <input type="checkbox"/>
052	Glasses/contact lens	Distance <input type="checkbox"/> Reading <input type="checkbox"/>
055	Color Deficient/Color Blind	
256	OTHER <u>SERIOUS</u> ILLNESS/INJURY/HEALTH CONCERN (LIFE THREATENING)	Description:
056	OTHER ILLNESS/INJURY/HEALTH CONCERN (NON-EMERGENCY)	Description:
000	<b>NO HEALTH CONCERNS AT THIS TIME</b>	
<b>New Students Only!</b>		Has your student ever attended a California Public School (including Kindergarten)? <input type="checkbox"/> Y <input type="checkbox"/> N
If “ <b>Yes</b> ” name <u>one</u> California School or School District attended.		

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

\_\_\_\_\_  
Date