MADISON COUNTY SCHOOLS

Student Health Form

School Year

School:	Grade:	Teacher:
Student's Name:	Date of Birth:	Gender: ☐ Male ☐ Female
Parent/Guardian Name(s):	Work Phone(s):	Cell Phone(s):
Transportation ☐ CAR ☐ BUS		
Local Physician / Healthcare Provider	Phone:	

STUDENT'S HEALTH HISTORY

CONDITION	NO	YES	LIST SYMPTOMS - MEDICATIONS NEEDED-COMMENTS
ALLERGY (life threatening) To food			ACTION PLAN REQUIRED (available in school office & on-line)
To medication			
To insects			
Asthma			
Seizure			
Diabetes -Must have DMMP from physician.			
Attention Deficit (ADD, ADHD)			
Birth Defect/Physical Handicap			
Bone / Joint Conditions			
Emotional/Psychological Disorder			
Headaches Migraine			
Cardiac Conditions			
Hypertension (High Blood Pressure)			
Blood Disorder / Sickle Cell			
Speech / Hearing Problems			
Gastrointestinal Conditions			
Surgery			
Vision Problems			Glasses? ☐ Yes ☐ No Contacts ☐ Yes ☐ No
Handicaps, special needs, or other medical concerns not listed			
Is the student taking daily medication			If **YES**, Please list:

I give my permission for my child to participate in the school's health program which may include health education and basic screening (vision, hearing, scoliosis, etc.). I give my permission for my child to receive standing orders/first aid care as needed. I give my consent for medical information to be shared between my child's medical provider and the school nurse. I consent that medical information may be shared with personnel who are directly involved with my child at school. It is the parent/guardian responsibility to notify the school of any medication or medical condition changes.

Parent/Guardian Signature: _____ **Date:** _____

Health forms and medical action plans are required each school year