

Spreckels Union School District

Student Health Information Form

STUDENT'S PREFERRED NAME			
First Name	Middle Name	Last Name	Suffix
Gender: <input type="checkbox"/>		Grade: <input type="checkbox"/>	
STUDENT HEALTH INFORMATION			

Please check applicable boxes below (attach additional documentation if necessary):

	Yes	No	Medication Taken	Comments/Explanation
Attention Deficit Disorder (ADD)				
Attention Deficit Hyperactivity Disorder (ADHD)				
Anaphylaxis or Severe Allergic Reactions				
Allergies (Seasonal, Food, Insects, Medications, Latex)				
Asthma or Breathing Problems				
Autism Spectrum Disorder				
Behavioral or Emotional Problems				
Diabetes				
Ear Problem or Deafness				
Eye/Vision Problems/Wears Glasses or Contacts				
Head Injury				
Heart Problems				
Learning Problems/Disabilities				
Limits on Physical Activity/Coordination Issues				
Meningitis				
Prenatal Complications/Prematurity				
Problem with Bladder/Bowels				
Seizures				
Speech Problems				
Surgery				
Other				
Is your student taking regular medication?				

Does the District have consent for following student screenings?

Vision			
Hearing			

If an emergency service involving medical action or treatment is required and parents/legal guardians cannot be reached for consent, signature below authorizes consent to the rendering of such emergency medical service for the above named student that shall be necessary in the opinion of the medical staff rendering the service.

Signature of Parent/Legal Guardian _____
Date

FOR DISTRICT USE ONLY			

Reviewed By Teacher Date of Review SIS Entry Date