

Harrison Community Schools

HEALTH INFORMATION SHEET

2007-2008

Student Name _____ Grade _____ School _____

Home Address _____ P.O. Box _____ City _____

Birthdate _____ Home Phone _____ Parent Work Phone _____

Family Doctor or Health Care Provider _____

HEALTH HISTORY

Emergency Medical Conditions/Problems: check ALL that apply

- | | | | |
|-----|-----------------------------------------------|--------|-------|
| 1. | Food allergies or reactions | ___yes | ___no |
| 2. | Medication allergies or reactions | ___yes | ___no |
| 3. | Bee stings or bug bite allergies or reactions | ___yes | ___no |
| 4. | Asthma or wheezing | ___yes | ___no |
| 5. | Eczema or frequent skin rashes | ___yes | ___no |
| 6. | Convulsions/seizures | ___yes | ___no |
| 7. | Heart trouble | ___yes | ___no |
| 8. | Hearing problems | ___yes | ___no |
| 9. | Fainting | ___yes | ___no |
| 10. | Diabetes | ___yes | ___no |
| 11. | Frequent headaches or migraines | ___yes | ___no |
| 12. | Hemophiliac or other bleeding disorders | ___yes | ___no |
| 13. | Takes medication regularly | ___yes | ___no |
| 14. | Other problems not listed | ___yes | ___no |

If you checked yes to any of the problem areas described above, or if your child has any physical, mental, or medical disabilities that we should be aware of, please explain:

(If necessary, you may write on the back of this sheet)

Please fill out the health information completely. If your child has a health condition that may require special treatment or an emergency plan, please contact the school nurse, Joy Robinson, RN, BSN at 539-0411, so an Individual Health Care Plan can be arranged.

Parent/Guardian Signature _____ Date _____