Harrison Community Schools

HEALTH INFORMATION SHEET

Student Name _____ Grade _____ School _____

Home Address _____ POB _____ City _____

DOB _____ Home Phone _____ Alt. 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 sting 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)	ADHD, ADD, Bi-Polar, OCD	____ yes ____ no
14)	Mental Disorders	____ yes ____ no

Please list all **medications** and **dosages** that your child takes at home or school:

_____

_____

_____

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/health consultant, Lori Cooper, LPN at 539-7871, ext 1007.

Parent/Guardian Signature _____ Date _____

Office use only

Revised 1/25/2012