



**Saint Alphonsus**

SCHOOL HEALTH PROGRAM

## Health Information Form 2023-2024

**Student Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Grade:** \_\_\_\_\_

Dear Parent/Guardian:

If your student has experienced changes to his/her health over the last year, please fill out and return this form to your school nurse. Please include any medication changes and new diagnoses that may impact your student's daily activities and learning.

\_\_\_\_\_ My child does **NOT** have any health concerns.

\_\_\_\_\_ My child **HAS** the following health concerns: (Please include any emergency instructions)

\_\_\_\_\_ Food Allergies/Treatments: \_\_\_\_\_

\_\_\_\_\_ Medication Allergies: \_\_\_\_\_

\_\_\_\_\_ Environmental Allergies/Treatments: \_\_\_\_\_

\_\_\_\_\_ Chronic Conditions: \_\_\_\_\_

\_\_\_\_\_ Medications:(home/school) \_\_\_\_\_

\_\_\_\_\_ Hospitalizations: \_\_\_\_\_

\_\_\_\_\_ Surgeries: \_\_\_\_\_

\_\_\_\_\_ Vision or Hearing Changes: \_\_\_\_\_

Other Pertinent Events: \_\_\_\_\_

My signature gives permission to share this health information with school staff and district transportation providers working with my child. This information will be used if necessary for safety at school, on field trips and other school activities. If medications are needed to be given to your child during school hours, please fill out and return a Medication Authorization Form.

Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

Parent Phone Contact \_\_\_\_\_

School Nurse \_\_\_\_\_ Date \_\_\_\_\_