STUDENT HEALTH INFORMATION FORM JHCD-AF5

PLEASE PRINT

ROLLA PUBLIC SCHOOLS

STUDENT'S LEGAL NAME

Last _____ First _____ Middle _____ Nickname _____

Gender: ☐ Male ☐ Female Date of Birth ____/____/____ Grade _____

Please share any medical information about your child that you believe district personnel need to know in order to effectively serve and educate your child. This information will be kept confidential and will only be shared with district staff when there is a reason for the staff member to have this information in order to fulfill his or her professional responsibility and in the case of a health or safety emergency.

Do any of the following conditions apply to your child? (Completion of this form is optional.)

Condition	Yes	No	Medication Name / Time / Dosage	Comments / Symptoms
ADD / ADHD				
Allergies (including food & medications)				
Asthma				
Bleeding Disorders				
Deformities				
Diabetes				
Ear Infections				
Gastrointestinal Problems				
Headaches				
Hearing Disorders				
Heart Disorders				
Kidney / Bladder Disorders				
Seizures				
Scoliosis				
Vision Disabilities				

Please list additional comments or concerns: _____

Parent/Guardian Signature _____ **Date** _____