Escalon Unified School District

SCHOOL HEALTH SERVICES
Current Health Information

Student Name:_____ _____
Last **First** **Initial** **Date of Birth**

School:_____ **Grade**_____

Yes	No	Does your child:	
		Wear □glasses **OR** □contacts?	If yes, date of last exam:
		Wear hearing aids or have a hearing problem?	If yes, please explain:
		Have allergic reactions? (check all that apply) □ Bees/insects □ Food(s) □ Medication(s) □ Other:_____	 Specify food(s)_____ Specify med(s)_____ Please explain:_____
		Have a prescription Epi-Pen?	
		Have an Epi-Pen at school?	If yes, please complete the Physician Certification form and return to the school office
		Have asthma?	If yes, current medications:
		Use an inhaler at school? *Location of inhaler:* □With student **OR** □in school office	If yes, please complete the Physician Certification form and return to school office
		Have diabetes?	If yes, current medications:
		Have seizures?	If yes current medications: Date of last seizure:
		Have bowel, bladder, or stomach problems?	If yes, current medications/treatment:
		Cardiac (heart) problems?	If yes, please explain and list current medications/treatment:
		Orthopedic (bone or joint) problem?	If yes, please explain and list current medications/treatment:
		Been diagnosed with ADD or ADHD?	If yes, please list current medications/treatment:
		Currently being seen by a physician for any condition not listed?	If yes, please explain:
		Take prescription medication during school hours?	Medication: If yes, please complete the Physician Certification form and return to the school office
		Has there been a major life change in your child's life that may affect their emotional well being?	If yes, please explain:

_____ _____
Date Parent/Guardian Signature