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| --- | --- |
| Gavin School District | **Grade \_\_\_\_\_** |
| Health Information Form |  |
| **2024-2025** |  |

Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |  |  |
|  | **CONCERNS** | **YES** | **NO** | **EXPLANATION** |  |  |  |  |
|  | Allergic to Bee Stings |  |  | Epi pen: | Yes | No |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
|  | Allergic to Medications |  |  | List: |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
|  | Allergic to Foods |  |  | List: |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
|  | Asthma |  |  | Medications: |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
|  | Seasonal Allergies |  |  | Medications: |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
|  | Attention deficit |  |  | With hyperactivity | Yes | No |  |  |
|  |  |  | Medications: |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  | Headaches |  |  | Medications: |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
|  | Migraines |  |  | Medications: |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
|  | Stomach problems |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
|  | Hearing Problems |  |  | Hearing Aids: | Yes | No |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
|  | Visual conditions |  |  | Glasses: | Yes | No |  |  |
|  |  |  | Contacts: | Yes | No |  |  |
|  |  |  |  |  |  |
|  | Diabetes |  |  | Pump: | Yes | No |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
|  | Cardiac/heart conditions |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
|  | Convulsions/seizures/epilepsy |  |  | Medications: |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
|  | Behavior/emotional concerns |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
|  | **Other medical concerns** |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |

In the event of an emergency as a result of serious illness or injury, permission is hereby granted to transport my child to a medical facility and to provide necessary treatment. I understand that an attempt will be made by the school administration and/or attending physician to contact me (or my spouse) in the most expeditious way possible. If said physician is not able to communicate with me (or my spouse) permission is hereby granted to the attending physician to proceed with necessary medical or surgical treatment and to admit him/her to a medical facility if necessary.

***Please note, documentation, for any medical condition, MUST be provided by a doctor.***

Parent/Guardian Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_