# TOMAHAWK SCHOOL DISTRICT

## STUDENT HEALTH FORM

It is important that the school be made aware of any health concerns or problems that may affect your son or daughter's ability to learn. Please complete the information below and return to the school office as soon as possible. This information will be reviewed by the school nurse and be a part of your child's confidential health record. Health information pertinent to school activities will be shared with the faculty directly involved with your son or daughter. Please note, all prescription medication will require practitioner signature to be given at school.

If you would like to discuss any concerns about your son/daughter's health with the school nurse, please contact the school office to arrange an appointment. Thank you for your cooperation.

Name of Student:_____Grade:_____Date of Birth:_____

Please check if applicable

| | | | | | |
|---|---|---|---|---|---|
| | Allergies | | Eye Glasses/Contacts | | Heart Condition |
| | Arthritis | | Epilepsy/Seizures | | Meningitis |
| | Asthma | | Frequent Earaches | | Kidney Problems |
| | Bone/Join/Muscle Problems | | Frequent Cold/Sore Throat | | Alcohol/Other Drug Abuse |
| | Chickenpox | | Frequent Stomaachaches | | Skin Problems |
| | Diabetes | | Hay Fever | | Tuberculosis |
| | Attention Deficit Disorder | | Emotional Distress/Depression | | Tumors/Growths/Cysts/Cancer |
| | Hearing Problems | | Anorexia/Bulimia | | Obesity |
| | Physical Disability | | Frequent Headaches | | Hormonal Problems |

If you responded yes to any of the above, please explain:_____

_____

_____

Are there any special emergency instructions for health problems, family matters which you think would be helpful for the school to know? _____

_____

_____

| Check if applicable. | | Explain if checked: |
|---|---|---|
| | Does your child take routine medication?<br>If so, give type, amount, and reason. | |
| | Do you know of any reason to limit your child's physical activities? | |
| | Has your child had any severe reactions/allergies to drugs, food, or bites & stings? | |

_____ _____

Parent/Guardian Name Parent/Guardian Signature Date