



Date: _____ School: _____

STAFF USE ONLY

- Child may not yet attend school
- Child may attend school; parent providing services
- Child may attend school; staff trained

SPECIAL HEALTH CONDITION INFORMATION

Student Name: (Last) _____ (First) _____ M or F _____ Teacher: _____
 Parent Name: _____ Birthdate: _____ Grade: _____
 Home Phone: _____ Address: _____
 Work Phone: _____ Cell Phone: _____
 Physician Name: _____ Address: _____ Phone: _____
 Pager: _____

Circle Yes or No

Yes No 1. Has your child been diagnosed with a medical condition? If yes, what is the diagnosis? _____

Yes No 2. Does this medical condition affect his/her participation in routine school activities programs? If yes, list any restrictions/special needs: _____

Yes No 3. Does your child take any medication? If yes, please list name(s) of medication and dosage: _____

Medication: _____ Dosage: _____
 Medication: _____ Dosage: _____
 Medication: _____ Dosage: _____

Yes No 4. Does your child require any special health procedure(s) during the regular school day? If yes, what is the procedure? _____

It is a parent responsibility to inform the school nurse immediately of any changes in your child's health status.

I affirm that the above statements are true to the best of my knowledge. I give permission for school personnel to contact my child's physician if needed.
Parent signature: _____

IUSD:75.80035 7/5/06 REV. **IUSD HEALTH SERVICES—PHONE (949) 936-7920**