Health & Allergy Form

Child's name: _____ DOB: _____ M / F Grade:_____

PLEASE CHECK ANY OR ALL THAT APPLY:

____ ADHD/ADD
____ Seizure
____ Diet or Nutritional problems
____ Diabetes
____ Physical handicap
____ Bi-Polar
____ Speech difficulties
____ Vision (wears glasses)
____ Weight problems
____ Frequent headaches
____ Pains in extremities or joints
____ Mental Health
____ ELL (English Language Learner)
____ Hearing difficulties
____ Special or poor eating habits
____ Frequent colds/sore throat
____ Heart condition

Further explanation of above items: _____

_____

If your child requires medication at school, a medication administration form must be completed.

____ Asthma (Please provide an Inhaler & complete Medication Administration Form)

____ Allergies (Please provide EPI pen & complete Medication Administration Form):

☐ Nuts ☐ Latex ☐ Eggs ☐ Strawberries
☐ Ibuprofen ☐ Bee Sting ☐ other: _____

Are activities restricted? ☐ Yes ☐ No If yes, explain: _____

Medications taken/given at home (please list name and dosage of any medication(s) your child is taking:

Name: _____ Dosage: _____ Name: _____ Dosage: _____
Name: _____ Dosage: _____ Name: _____ Dosage: _____

Currently under a physician's care? ☐ Yes ☐ No Doctor: _____ PH: _____

For what reason: _____

Parental authorization

I hereby give my consent to MHMS to receive from or send to Dr. _____/Health Care Provider any information concerning my child.

Parent's signature: _____ Date: _____

Office use:

Date received: _____ Revised: 08/15/2018