



Health & Allergy Form

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

PLEASE CHECK ANY OR ALL THAT APPLY:

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

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):

- | | | | |
|------------------------------------|------------------------------------|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Nuts | <input type="checkbox"/> Latex | <input type="checkbox"/> Eggs | <input type="checkbox"/> Strawberries |
| <input type="checkbox"/> Ibuprofen | <input type="checkbox"/> Bee Sting | <input type="checkbox"/> 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 MHS 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