ANNUAL HEALTH INFORMATION

Dear Parent/Guardian: The information on this form will be used to meet your child's health needs at the school. Please complete all sections of the form and then sign and return it to your child's teacher as soon as possible. Every student must have a new form completed each year.

School Name:	Grade:	Is your child new to the district? ☐ Yes ☐ No

Student's Last Name:	First Name:	Middle Name:	Suffix (Jr., III, etc.)

Date of Birth: / /

Parent/Guardian Name:	Relationship to student:
Home or Cell Phone: ( )	Work Phone: ( )
Health Care Provider Name:	Health Care Provider Phone: ( )
Date of last physical: / / ☐ Unsure	Date of last dental exam: / / ☐ Unsure

What type of insurance does your child have?
- ☐ Medicaid
- ☐ Private
- ☐ Unsure
- ☐ My child does not currently have insurance

If your child has Medicaid, please mark the plan name:
- ☐ Aetna
- ☐ Blue Cross Complete
- ☐ HAP Midwest
- ☐ McLaren
- ☐ Meridian
- ☐ Molina
- ☐ Total Health Care
- ☐ United
- ☐ Other

Does your child have any of the following health conditions?

HEALTH CONDITION	YES	NO
Severe allergies (food, insects, drugs, latex) If yes, please state what your child is allergic to (certain foods, insects, latex, etc) If yes, please check the reaction that occurs: ☐ Hives ☐ Swelling ☐ Trouble breathing ☐ Other		
Allergies (seasonal)		
Anxiety		
Asthma or breathing problems		
Attention Deficit Hyperactivity Disorder		
Behavioral Problems		
Bladder or Bowel Problems		
Dental Problems		

HEALTH CONDITION	YES	NO
Depression		
Diabetes		
Head Injury or Concussions		
Hearing Problems		
Heart Problems		
Lead Poisoning		
Pregnant		
Seizures		
Sickle Cell Disease		
Speech Problems		
Vision Problems		
Wears Glasses		
Other Health Conditions, please list:		

MEDICATIONS AND/OR SPECIAL PROCEDURES*

Does your child require any daily medications to be taken at school?	☐ Yes*	☐ No
Does your child require any emergency medications be kept at school?	☐ Yes*	☐ No
Does your child require any special procedures to be done at school? (g-tube feeding, catheterization, etc.)	☐ Yes*	☐ No

***If you answered yes to any of the above questions under Medications and Special Procedures, please have your child's health care provider complete the attached medication/procedure authorization form. The form must be signed by both the health care provider and the parent, and must also be renewed every year.**

FAMILY NEEDS

In the last 12 months, did you ever eat less than you felt you should because there wasn't enough money for food? ☐ Yes ☐ No

ACKNOWLEDGMENTS & SIGNATURE

I certify that this information is correct to the best of my knowledge and understand that it is my responsibility to inform the school if any of this information changes. I also understand that this information may be shared with need-to-know staff at my child's school in order to keep my child safe and protected while at school.

Parent or Guardian Signature ______________________ Print Name ______________________ Date ____________

TO BE COMPLETED BY OFFICE STAFF

	DATE	STAFF PERSON
Form Received		
Information entered into Student Information System		

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