THE Vanguard School

STUDENT HEALTH INFORMATION
School Year: _____

STUDENT NAME:_____Birthdate:_____Grade:____

HEALTH CONCERNS	YES	NO	MEDICATION (Name, Dosage, Home or School)	NECESSARY MONITORING IN SCHOOL	DIAGNOSIS OR DESCRIBE
DIABETES				PLEASE PROVIDE PHYSICIAN ORDERS	
ALLERGIES: (CIRCLE) ***FOOD - *INSECTS - *LATEX - MEDICATION - ENVIRONMENT**				*PLEASE PROVIDE HEALTH CARE PLAN FROM PHYSICIAN	
ASTHMA/RESPIRATORY				PLEASE PROVIDE HEALTH CARE PLAN FROM PHYSICIAN	
SEIZURES				PLEASE PROVIDE HEALTH CARE PLAN FROM PHYSICIAN	
PREVIOUS CONCUSSION/ HEAD INJURY					YEAR:
MIGRAINES					
HEART/BLOOD					
MUSCLES/BONES/ JOINTS/SKIN					
BLADDER/KIDNEY					
STOMACH/INTESTINES/ BOWELS					
AUTOIMMUNE					
MENTAL HEALTH: (CIRCLE) DPRESSION- ANXIETY- OTHER					
ADHD/ADD					
AUTISM SPECRUM DISORDER					
GROWTH & NUTRITIONAL CONCERNS					
HEARING/VISION CONCERNS					
OTHER CONCERN					
IEP/504					

- Activity restrictions in school?_____
- Have there been any significant changes in your child's health including illnesses, hospitalizations, accidents or injuries over the last year: (use other side if necessary)_____

The School nurse may develop a Student Health Care Plan each school year. All information is considered confidential and is shared only on a need-to-know basis. I give my permission to inform teachers and necessary staff about my child's identified health concerns.

Parent/Guardian Signature_____Date_____

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