

St. Paul the Apostle School
School Health Record
2011-2012

Last name of Student _____ First Name of Student _____

Grade _____ Homeroom teacher _____

Names of parents or guardians _____

Family Doctor _____ Phone _____

Family Dentist _____ Phone _____

Lead test (children age 6 years or under) Date _____ Result _____
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Please circle yes or no:

YES NO Is your child allergic to medication, food, bee stings, or environmental allergens?
If yes, list name and reaction _____

YES NO Does your child take medication (s) on a routine basis?
If yes, list name and times taken _____

YES NO Does your child have a medical diagnosis of a chronic health condition such as diabetes, asthma, heart problems, seizures, etc?
If yes, list condition _____

Please list any additional health related concerns that you would like to have reviewed by the Scott County Health Department nurse:

This document is used for evaluating the physical and emotional condition of each student to meet the student's health needs. This health information may be shared with the school and health staff for the purpose of meeting student health and learning needs.

Parent / Guardian signature _____ Date _____