MONONGALIA COUNTY SCHOOLS
STUDENT HEALTH INFORMATION FORM
School Year _____

Student's Name _____ DOB _____ School_____

Homeroom Teacher_____ Grade _____ Student ID # _____

Parent/Guardian #1 Name_____ Relationship to Student_____

Home Phone _____ Work Phone _____ Cell Phone_____

Parent/Guardian #2 Name_____ Relationship to Student_____

Home Phone _____ Work Phone_____ Cell Phone_____

Hospital Preference ___ WVU/Ruby ___ Mon General Medication Allergies _____

State guidelines recommend that the school nurse obtain a health history on every child yearly. Please complete this form and if no health problems exist check the box at the bottom of the page. Sign form and return it to school as soon as possible. All information will be kept confidential among appropriate school personnel. Feel free to contact your child's school nurse with any further concerns or questions.

◊ Student's current medical/mental health issues as <u>DIAGNOSED BY PHYSICIAN</u>. Please check all that apply.

Condition	Yes	Comments	Condition	Yes	Comments
Allergies (food, insects, drugs, latex)			Diabetes		
Allergies (seasonal)			Head injury, concussions		
Asthma			Hearing issues or deafness		
Attn.-Deficit/Hyperactivity Disorder			Heart problems		
Behavioral problems			Migraine Headaches		
Developmental problems			Muscle problems		
Bladder problem			Seizures		
Bleeding problem			Sickle Cell Disease		
Bowel problem			Speech problems		
Cerebral Palsy			Spinal injury		
Cystic Fibrosis			Surgery		
Dental problems			Vision problems		
Other:			Other:		

Comments on above: _____

Medications: At home _____

At School_____

Remember: All medication at school requires a completed medication form by a licensed prescriber.

Special Diet (Medical Reason Only)_____
REMEMBER: **Diet accommodations will not be made without a *licensed prescriber's order.***

I have completed the above information. I understand that the school nurse may share the above information confidentially with appropriate school personnel that work with my child during the school day.

☐ **No known health problems**

_____/_____
Parent /Guardian's Signature **Date**