Scurry-Rosser ISD

HEALTH INFORMATION CARD

Dear Parents,

It is vital that we receive the following information in the school clinic so that we may provide both emergency and routine health care for your child at school. Please complete this entire form and notify me of any changes (phone number, address, physician name, etc.) as they occur during the school year.

Thank You,

Your School Nurse

_____

Student Name

NOTE: PLEASE COMPLETE AND SIGN MEDICAL INFORMATION BELOW:

PLEASE CHECK IF APPROPRIATE:

_____ Attention Deficit Hyperactivity Disorder

_____ Asthma

Trigger _____

_____ Blood Disorder

_____ Diabetes

_____ Dyslexia/Learning Disability

_____ Eating Disorder

_____ Epilepsy/Seizure Disorder

_____ Hearing Disorder

_____ Heart Condition

_____ Kidney Disorder

_____ Migraine Headaches

_____ Muscular/Orthopedic Disorder

_____ Psychiatric/Psychological Disorder

_____ Serious Accident

_____ Special Needs

I yes to any of the above, please explain: _____

ALLERGIES: Medication: _____

Food: _____

Other: _____ Reaction: _____

Recommended treatment if allergy is severe: _____

Is your child on any medication? Named of Medication: _____

Dosage: _____ For what reason? _____