

Dear Parents/Guardians,

Your student's health information needs to be updated every year to ensure his/her safety. This form is part of registration and must be completed and signed. It will be incorporated into your student's permanent record. If you have circled or indicated any health problem, it is important that you provide an explanation in the area provided. It is the responsibility of the parent/guardian to notify the school of any significant health concerns.

Note: Health information will be provided to appropriate personnel, as necessary, to ensure a safe and supportive environment for each student. The following general guidelines are provided to assist you in determining disability information:

**ASTHMA**

- 1. Moderate to severe attack within the last two years.
- 2. Receiving medication for asthma.
- 3. P.E. excuse for asthma.

**ADD/ADHD**

- 1. Requires medical diagnosis.

**POTENTIALLY SEVERE REACTION**

- 1. Life threatening.

**VISUAL IMPAIRMENT**

- 1. Vision not fully corrected with glasses.
- 2. Medical diagnosis associated with vision loss.

Always include an emergency contact number!

Thank You.

**Supplemental Health Card**

(Please read the back for information prior to completing this form)

Name Last	First	M.I.	Student #	School/Year
Sex	Birthdate	Grade	Last School Attended	

Current Health Problems (Circle At Least One) (\*Must Have Medical Diagnosis)

<b>No Known Disability</b> Asthma/Airway Disorder* _____ Blood Disorder* _____ Food Allergy To _____ Diabetes* _____ Seizures*; Type _____ Genetic Syndrome* _____ Glasses/Contacts _____ Hearing Aid (R) _____ (L) _____ Hearing Impairment _____ Immunization Exemption (Only _____ MedicalDD/ADHD* _____ Cancer* _____ Migraines* _____	<b>Multiple Disabilities (More than 4)</b> Neurological Disease* _____ Muscular Disease* _____ Orthopedic Problem* _____ Potentially severe reaction to _____ Environmental Hypersensitivity to _____ Skin Disorder _____ Heart Problem* _____ Visual Impairment* _____ Color Blindness* _____ Exempt From Physical Screening _____ Psychological Disorder _____ Other _____	<b>Explain Circled Health Problems:</b> _____ _____ _____ _____ _____ _____ _____ _____ _____
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NOTE: HEALTH INFORMATION WILL BE PROVIDED TO APPROPRIATE PERSONNEL AS NECESSARY, TO ENSURE A SAFE AND SUPPORTIVE ENVIRONMENT FOR EACH STUDENT

RECEIVING MEDICATION? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, NAME OF MEDICATION _____
ABLE TO TAKE P.E./RECESS? <input type="checkbox"/> YES <input type="checkbox"/> NO	IS MEDICATION NEEDED AT SCHOOL? <input type="checkbox"/> YES <input type="checkbox"/> NO
(Must provide medical documentation regarding limitations)	
PARENT/GUARDIAN SIGNATURE _____	DATE _____