Spearfish School District 40-2

Health Information

Student_____ **Date of Birth** _____ ◯ **Male** ◯ **Female**

Primary Physician_____ Dentist_____

Medicaid Number_____

Medications

Name	Dose	Frequency	Reason	Prescribing Dr.

☐ Inhaler *(fill out Asthma Action Plan)* ◯ Student Self-Carries Medication ◯ Medication will be brought to school nurse

Health Conditions

Allergies (include reaction)_____

_____

☐ Epi-pen *(fill out Allergy Action Plan)*

Dietary Limitations_____

☐ Seizures/ Epilepsy (date of last seizure)_____

☐ Heart Condition	☐ Hearing impairment	☐ Frequent headaches
☐ Diabetes	☐ Bowel/Bladder issues	☐ Wears glasses/contacts
☐ Asthma	☐ Frequent ear infections	☐ Other (please explain)

History Please list any surgeries or hospitalizations

_____

_____

_____

This information is accurate to the best of my knowledge. I have received and read a copy of SSD 40-2's illness policy. I understand it is my responsibility to keep the school informed of any changes or additions to my child's health information or conditions.

Signature of Parent/Guardian_____

Printed Name_____ Date_____