

ALPINE SCHOOL DISTRICT
STUDENT HEALTH INFORMATION

Student's Name _____ Birth Date _____ Sex _____
Address _____ City _____ Grade _____
Home Phone _____ Cell Phone _____ Other Phone _____
Parent/Guardian: _____
Parent/Guardian email: _____
Student lives with: _____ both parents _____ Mother _____ Father _____ Other _____

MEDICAL HISTORY

Family Doctor _____ Phone _____
Current Medical Diagnosis (if any) _____

YES	NO	HAS YOUR CHILD EVER HAD (if yes, please describe)
_____	_____	Any Allergies (Please specify to what and how serious)? _____
_____	_____	Asthma or Breathing Problems (how serious)? _____
_____	_____	Orthopedic or Bone Problems? _____
_____	_____	Heart Disease or Murmur? _____
_____	_____	Kidney Disease? _____
_____	_____	Seizures (type and frequency)? _____
_____	_____	Diabetes (Insulin dependant? On an insulin pump?) _____
_____	_____	Serious or Chronic Disease (i.e. Leukemia, transplant)? _____
_____	_____	Has your child had the Chickenpox disease? _____
_____	_____	Serious Accident/Injury? _____
_____	_____	Vision Exam? Date _____ By Whom _____ Results _____
_____	_____	Other Health Concerns? _____

MEDICATION

Is student on special medication that may need to be administered during school?
/es*** (See below) _____ No _____ If yes, what type(s) and reason: _____

***If Yes, a student medication authorization form must be completed by parent and physician and returned to the school before any medication can be given. This includes all OTC (over the counter) and prescription medications (including inhalers, EpiPens and insulin). You can obtain the form from the office.

IT IS A VIOLATION OF THE DISTRICT'S DRUG-FREE POLICY FOR STUDENTS TO CARRY ANY MEDICATION. The only exception to this is inhalers, EpiPens and insulin with proper signed prescriber and parent authorization.

Signature of Parent/Guardian _____ Date _____

PLEASE NOTE: The information requested is considered to be essential for planning a program each year which will meet the needs of your