FREMONT COUNTY SCHOOL DISTRICT #1
STUDENT HEALTH INFORMATION

Student's Name____BirthDate____________Sex____

Address____City________________Grade______

PrimaryParent/Guardian_____________________1st phone #__________2nd phone #__________

Secondary Parent/Guardain___________________1st phone #__________2nd. Phone #__________

Student lives with: _____both parents_____Mother_____Father_____Other:_______________

YES NO HAS YOUR CHILD EVER HAD (if yes please describe)

___ ___ Allergies_________________________Reaction:__________________________
Treatment:____

___ ___ Vision/Hearing problems____

___ ___ Depression/Anxiety/Attention Disorders_______________________________

___ ___ Asthma, Triggers:___________________________frequency_______________
Treatment (inhaler):____

___ ___ Heart issues____

___ ___ Kidney disease____

___ ___ Seizures (type & frequency)____

___ ___ Diabetes____

___ ___ Serious or Chronic Disease____

___ ___ Chickenpox (when)____

___ ___ Serious accident/injury____

___ ___ Other____

MEDICATIONS: please list all medications your child takes including directions.
(PLEASE READ PAPAGRAPH BELOW REGARDING MEDICATION ADMINISTRACTION)

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If your child requires prescription medications during school hours a medication authorization form must be completed by parent and physician and returned to the school **BEFORE** any medication can be given. If your child requires OTC (over the counter) medications during school hours (Tylenol, ibuprofen) a medication authorization form must be completed by the parent and returned to the school with the desired medication in its original bottle. You may obtain all medication forms from the Health 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______________