

Tripoli Community School District Health Information

Please complete the following information to promote and protect the health of students

Name of Student _____ Grade _____

Does your child have: (please circle)

Yes	No	Asthma or Bronchospasms	Yes	No	Diabetes
Yes	No	Heart Problems	Yes	No	Seizures
Yes	No	Blood Pressure Problems	Yes	No	Migraine Headaches
Yes	No	ADD or ADHD	Yes	No	Depression
Yes	No	Kidney or Urinary Problems	Yes	No	Anxiety
Yes	No	Hearing Concerns	Yes	No	Stomach or Bowel Problems
Yes	No	Vision Concerns			
		Does s(he) wear glasses and/or contacts?	Glasses	Contacts	Both None

Comments: _____

Medication	Dose	Frequency	Diagnosis	Doctor	Given at School?
					YES NO
					YES NO
					YES NO

Yes No Does your child have any allergies? If yes to what is s(he) allergic? _____

What is the reaction? _____

Yes No Has your child had any surgery, serious illness or injury **over the summer**? Please explain and give approximate date: _____

Yes No Does your child have any other health concerns that you feel would be helpful for the school to know? _____

Yes No Do I have your permission to share this information with appropriate school personnel?

Please read and sign below:

In the event that the parent and/or emergency contacts cannot be contacted, the school officials are hereby authorized to take whatever action is deemed necessary in their judgement for the health of the aforesaid child/children. I will not hold the school district financially responsible for the emergency care and/or transportation for said child/children.

Signature of Parent/Guardian _____ Date _____

Thank you for your response in helping to update your child's health record.