NEWELL-FONDA CSD HEALTH HISTORY 2025-26

Please Check Those Conditions That Apply

Medications (please include inhalers)

Student Last Name	Student First Name	Grade	Diabetes	Heart	Mental/Behavior	Seizures	Vision/G or C	Migraines	ADHD/ADD	Hearing	Urinary	Asthma/Inhaler?	Special Diet	Other	Allergies (medication,latex or food)	Name of Medicine	Taken @ home	Taken @ School

*if taking at school, please fill out a med. permission sheet. If your child has a food allergy or asthma, please provide the school with an Allergy/Asthma Action Plan from your doctor.

Doctor: _____ City: _____ Approx. Last Visit: _____

Dentist: _____ City: _____ Approx. Last Visit: _____

Eye Doctor: _____ City: _____ Approx. Last Visit: _____

Insurance

Please Check Child's Current Health Coverage:

Hawk-i	Title 19	Medical	Dental	Vision	None

If I cannot be reached, the Newell-Fonda Community School may disclose medical information regarding my child to the people listed as my "alternative arrangement". In a medical emergency, I hereby authorize the school district to seek emergency medical assistance for my child. I also agree to pay the fees for the emergency medical treatment as authorized under this consent. I understand that my child's health information is confidential but may be shared with appropriate school personnel on a "need to know" basis, under the Family Educational Rights and Privacy Act (FERPA). I give my permission for my above listed children to have any or all of the following screenings: vision, height/weight/BMI, hearing, scoleosis and dental. I authorize my child's medical provider or public health provider to provide/receive my child's immunization information to/from Newell-Fonda School.

_____ _____

Parent/Guardian Signature Date