Salmon River Jr-Sr High School
Health Information

Student Name: _____

Date of Birth:_____ Grade:_____

Dear Parent/Guardian/Student:

Please complete this health information form. This information may be shared with the student's teacher(s) and administration to promote and protect the health of students but otherwise is completely confidential.

☐ Medications taken at home ☐ Medications taken at school – Please fill out "Authorization for Medication Administration" Form

Has your child ever been diagnosed with:

☐ ADD/ADHD

☐ Allergies

☐ Bee/insect Specifically_____

Reaction:_____ Treatment:_____

☐ Food Specifically_____

Reaction:_____ Treatment:_____

☐ Medication Specifically_____

Reaction:_____ Treatment:_____

☐ Asthma Symptoms: _____ Treatment:_____

☐ Behavioral or emotional concerns: _____

☐ Cardio/Pulmonary concerns: _____

☐ Depression

☐ Diabetes ☐ Insulin Dependent ☐ Non –Insulin Dependent

☐ Headaches/Migraines Frequency:_____ Treatment:_____

☐ Hearing concerns Describe: _____

☐ Kidney or urinary concerns: _____

☐ Muscle/Joint/Bone concerns: _____

☐ Seizures Type: _____ Frequency: _____

☐ Vision: ☐ Contacts ☐ Glasses ☐ Vision Loss ☐ Other _____

Does your child have a LIFE THREATENING illness or condition that will require a health plan? ☐ Yes ☐ No

If yes, please explain:_____

_____