Community Health Network

STUDENT'S NAME _____DOB _____
SCHOOL _____ GRADE _____ TEACHER _____

Dear Parents,

It is important for the school to be aware of any special health concerns your child may have that affect him/her while during the school day. Health needs often change, so information should be updated each year. Please complete and return this form to school.

_____ My student has no health problems or limitations that will affect him/her at school.
_____ My student has the following medically-diagnosed health concerns that may affect him or her during the school day. (Please check box/boxes and EXPLAIN below):

_____Asthma
_____Allergies (life-threatening)**
_____Bees/Insects
_____Foods
_____Latex
_____Bone/Joint Problems
_____Cancer
_____Diabetes
_____Hearing or Vision Deficits (not glasses)
_____Heart Condition
_____High Blood Pressure
_____Kidney Problems
_____Seizures or Epilepsy
_____Other (Explain Below)

PLEASE LIST ANY ALLERGIES TO FOOD OR MEDICINE, OR EXPLAIN ABOVE:

_____

_____

_____

****IF the student is new to OR re-enrolling in _____school and has a serious health condition or life-threatening food allergy requiring epinephrine, please know that doctors' orders are necessary for diagnosing and altering a USDA school meal. Please have your child's doctor-signed action plan and appropriate medications to the school nurse as soon as possible.**

*Health information is confidential. The school nurse cannot share this information with the faculty/staff at your child's school without signed parent permission. If it is medically necessary for the above medical information to be shared with the staff please sign below and contact the Community school nurse at your child's school.

_____ _____
Date Parent/Guardian Signature and Telephone Number