GLENFOREST SCHOOL
A Positive Place to Learn

Glenforest Health Room Information for 2024 - 2025

Student's Name: _____ Birthdate: _____

Mother's/Legal Guardian's Name: _____

Home #: _____ Work #: _____ Cell #: _____

Mother's Email Address: _____

Father's/Legal Guardian's Name: _____

Home #: _____ Work #: _____ Cell #: _____

Father's Email Address: _____

Physician's Name: _____ Physician's #: _____

Dentist's Name:_____ Dentist's #: _____

Preferred Hospital: _____

Insurance Provider: _____ Policy/Group Numbers: _____

Allergies: _____

Physical Conditions (i.e. wears glasses): _____

Diagnoses/Medical Reactions: _____

Does your student take medication daily? Yes No Given at (circle one) Home School Both

List medications and doses below.

Medication	Dosage	Time Taken

PLEASE COMPLETE THE BACK SIDE OF THIS FORM

Please check and explain any health condition DIAGNOSED BY A LICENSED HEALTHCARE PROVIDER.

Check	Condition	Explanation
	ADD/ADHD	
	Allergies _____Food _____ Insects _____Seasonal _____ SEVERE REQUIRING AN EPIPEN (2 should be kept at school)	
	Anemia	
	Asthma (Inhalers should be available at school with completed medication forms on file)	
	Bladder/Urinary Condition	
	Bone/Orthopedic Condition	
	Diabetes	
	Epilepsy (Seizures) Last Episode:	
	Fainting Spells (Syncope)	
	Genetic Condition	
	Heart Trouble Corrected? Y N	
	Hemophillia/Bleeding Disorder	
	High Blood Pressure	
	Mental Illness Type:	
	Vision Problems Glasses? Y N Last exam:	
	Hearing Problems Hearing Aid? Y N Ear: Left Right	
	Reactive Airway Disease	
	Sickle Cell Last Crisis: Last Hospitalization:	
	Skin Disorder	
	Tuberculosis (TB)	
	Other:	

Medication should be brought to the health room in its original container and the appropriate forms should be completed prior to a student receiving medicine at school. Parental consent is required for non-prescription medication and both parental and student's healthcare provider (Physician) signatures are REQUIRED for prescription medication.

I GIVE THE SCHOOL NURSE PERMISSION TO CONTACT THE LICENSED PRESCRIBER AND/OR SHARE THE ABOVE INFORMATION WITH THE SCHOOL STAFF AS NECESSARY FOR MEETING MY CHILD'S EDUCATION NEEDS.

Parent's/Legal Guardian's Signature _____

Parent's/Legal Guardian's Printed Name _____ Date _____