HEALTH INFORMATION FORM

Alsea School District 7J
301 South 3rd Street
Alsea, OR 97324
www.alsea.k12.or.us

Student Name: _____ **Grade:** _____ **Date of Birth:** _____

The following information is considered confidential and is for use by Alsea School District staff who will be in contact with and responsible for your child during the school day.

If you would prefer taking to us personally regarding any of the following statements, please initial here _____ and we will get in contact with you.

Medical Condition	Yes	No	If YES, fill out this column	Additional Information
Asthma			What triggers the asthma?	Does your child use an inhaler: Yes No
Food Allergies			Please list food(s) allergic to: Please describe the reaction:	Is medication required? Yes No Describe treatment:
Other Allergies			If YES, what is your child allergic to? Please describe the reaction:	Is medication required? Yes No
Diabetes			Please talk to the staff to determine a treatment plan while at school.	Is medication required during the school day? Yes No
Seizures			Is there something specific that triggers the seizures?	Is medication required? Yes No
ADD or ADHD				Is medication required during the school day? Yes No
Any Other Medical Conditions			Please list:	Is medication required during the school day? Yes No
Are you concerned about the child's **vision?**			Please explain:	
Are you concerned about the child's **hearing or speech?**			Please explain:	