ISD #484 Pierz Schools
Confidential Health Form 2023-24

Please complete this form and return as soon as possible to your child's school. All information is confidential, and shared only with those who work directly with your child. This information is important to best serve and care for your child.

Name:__________________________________ DOB: __________ Grade:________

Doctor/Clinic: ____________________________

Allergies: ____

Daily medications

Medication Dose Time of day:

1. ____
2. ____
3. ____

I have concerns about my child's:

☐ Vision ☐ Hearing ☐ Weight (low | high)

Medical interventions needed at school:

☐Contacts ☐EpiPen ☐Glasses ☐Hearing aids (right | left | bilateral)

☐Inhaler ☐Nebulizer ☐Medication

HIGH RISK HEALTH CONDITIONS:

☐ Asthma ☐ Bee Sting Allergy ☐Food Allergy ☐Diabetes ☐Seizures/Epilepsy

OTHER HEALTH CONDITIONS:

☐No known health conditions

☐ADD/ADHD	☐Allergy (Medication)	☐ Anxiety
☐Autism	☐Autoimmune disorder	☐ Behavior disorder
☐Bowel or bladder disorder	☐Depression	☐Developmental delay
☐Emotional concern/disorder	☐Genetic disorder	☐Head injury (significant)
☐Hearing impairment	☐Heart condition	☐Kidney disorder
☐Major surgery	☐Neurological disorder	☐Seasonal Allergies
☐Sensory processing disorder	☐Skin condition	☐Speech impairment
☐Visual impairment		

☐ Other health condition(s): ____

Please specify/describe any conditions selected above:

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Additional information you would like us to know about your child: ____

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Parent Signature: ____ Date: _______________