DETROIT ACADEMY OF ARTS & SCIENCES SCHOOL DISTRICT

Student Health Information Form

Student Name _____ School Year _____
Grade _____

Allergies:

☐ My child has **no known** allergies.

☐ My child has allergies to:

☐ Food (please list)

_____

☐ Medicine (please list) _____

☐ Other (please list) _____

Medical Conditions:

☐ My child has **no known** medical conditions.

☐ My child has one or more of the following medical conditions:

☐ Asthma
☐ Frequent Nose Bleeds
☐ ADD/ADHD
☐ Eczema
☐ Sinus Infection
☐ Anxiety
☐ Other (please explain)

☐ Seizures
☐ Sickle Cell
☐ Bladder Issues
☐ Cancer
☐ Ear Infection
☐ Migraines

_____

Medications:

☐ My child does not take medication for his/her medical condition.

Asthma: ☐ My child carries their inhaler with them and self-medicates as needed.
☐ My child needs to be administered their asthma medication by an adult.
(please complete a Permission to Administer Medication form)

Other Medication(s): _____

☐ My child takes this medication at home and does not need to be administered medicine at school.
☐ My child will need to be administered their medication at school.
(please complete a Permission to Administer Medication form)

(Over)

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Additional Health Information:

_____

_____

_____

_____

PARENT/GUARDIAN AUTHORIZATION:

I/We request designated school personnel to administer medication as prescribed if needed. I/We certify that I/we have legal authority to consent to medical treatment for the student named above, including the administration of medication at school. I/We understand that at the end of the school year, an adult must pick up the medication, otherwise it will be discarded. I/We authorize the school nurse to communicate with the health care provider as allowed by HIPAA.

Signatures:

Parent/Legal Guardian Signature: _____ Date: _____

Parent/Legal Guardian Phone Number: _____

This document to be completed every school year