DEKALB COUNTY SCHOOL SYSTEM
STUDENT HEALTH INFORMATION

Student's Name _____

M or F (please circle one) Birth Date_____ Grade_____

School_____ Date_____

Please check any of the following that applies to student:

_____ADD
_____ADHD
_____Allergies; Specific type_____
Is EpiPen required? Yes ___ No___
_____Asthma
_____Reactive Airway
_____Frequent Bronchitis
_____Chemotherapy / Immunosuppression
_____Cystic Fibrosis
_____Depression
_____Diabetes: Type 1___ Type 2____
_____Eating Disorder
_____Underweight
_____Overweight
_____Head Injuries
_____Hearing Loss
_____Heart Disease
_____Hemophilia
_____Hepatitis
_____Hypertension
_____Injury, Major
_____Kidney Disease
_____Leukemia
_____Nosebleeds (frequent)
_____Organ Transplant
(Please circle) Liver /Heart /Kidney
_____Orthopedic Problems
_____Migraine Headaches
_____Muscular Dystrophy
_____Pityriasis Rosea
_____Pneumonia
_____Psoriasis
_____Rheumatic Fever
_____Seizure Disorder
_____Sickle Cell Anemia
_____TB
_____Vision Loss

If this student has any of the above, did he/she receive medical care? Yes____ No____

Is the student under medical treatment now? Yes___ No_____

If yes, what kind of medical treatment? _____

Is the student on any kind of medication(s)? Yes____ No_____

If yes, please list medication(s) _____

_____

NOTE: **Please see school health personnel for a Doctor/Parent Medication Permission Form. A Physician MUST sign a form for EACH medication to be taken in school.**

_____ _____

Parent /Guardian Signature **(Phone Number)**

THIS INFORMATION IS CONFIDENTIAL AND OPTIONAL. PLEASE RETURN FORM TO CLINIC AT YOUR SCHOOL.

7/2007