

SPARTANBURG DISTRICT FIVE STUDENT HEALTH FORM- DUE APRIL 15TH

All information on this form will be kept strictly confidential

STUDENT NAME _____

FAMILY PHYSICIAN _____ PHONE _____

FAMILY DENTIST _____ PHONE _____

STUDENT HEALTH HISTORY

FOOD ALLERGIES _____

DRUG ALLERGIES _____

ENVIRONMENTAL/SEASONAL ALLERGIES _____

STUDENT PRESCRIPTION MEDICATION LIST: (List all medications student is currently taking at home and/or school)

MEDICATION _____ DOSE & TIME _____ REASON FOR MEDICATION _____

MEDICATION _____ DOSE & TIME _____ REASON FOR MEDICATION _____

RECORD OF ILLNESS, HEALTH PROBLEMS THE STUDENT CURRENTLY HAS OR HAS A HISTORY OF:

ADD/ADHD		Stomach problems/Gastric Reflux		Bladder/Kidney	
Arthritis		Frequent Headaches		Bowel/Colon	
Autism		Migraines		Vision/Glasses/Contacts	
Asthma		Heart Disease		Hearing Aid/Hearing Loss	
Diabetes type I, IDDM		Seizures		Mental Health/Emotional Condition	
Diabetes type II, NIDDM		Dizziness/Vertigo		Mobility Devices	
Hypoglycemia		Skin Disorder		Other	

This is permission for treatment by a physician and at a hospital for any medical or surgical EMERGENCY ONLY.

Name of Health Insurance Company _____

Group or Identification Number _____

Any other information you may want to give pertaining to your health history (use back if needed):



Signature of Parent/Legal Guardian

Date

TO SEND THIS ELECTRONICALLY PLEASE SCAN, CREATE PDF OR TAKE A PIC AND SEND TO: RRBandforms@gmail.com