

**Adams County Ohio Valley School District  
School Nurse Health Information Form**

Student's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Grade \_\_\_\_\_

Dear Parent/Guardian:

It is very important that we have accurate and up-to-date health information for your child. Please indicate any health problem(s) your child may have by checking the appropriate line(s). Please be sure and indicate any medical problems on your child's Emergency Medical Authorization form as well.

Asthma	_____	Does your child use an inhaler? _____ If so, will your child use it at school? _____ Does your child need to carry their inhaler with them at school? _____
Diabetes	_____	Does your child take insulin? _____ Will your child check their blood sugar at school? _____
Seizures	_____	Does your child need DIASTAT at school? _____
Bee Sting Allergies	_____	Does your child need an EpiPen at school? _____
Food Allergies	_____	What foods is your child allergic to? _____ _____ Does your child need an EpiPen at school? _____
Latex Allergy	_____	
Allergies to medications	_____	What medications? _____
Vision Problems	_____	Type of problem _____
Hearing Problems	_____	Type of problem _____
Cystic Fibrosis	_____	
Cerebral Shunt	_____	
Heart Problems	_____	Diagnosis _____

Any other medical problem not listed above? \_\_\_\_\_  
\_\_\_\_\_

**My child has no known medical problems.** \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_