

# Eanes Independent School District Health Information

Name \_\_\_\_\_ Sex \_\_\_\_\_ Grade \_\_\_\_\_ Birthdate \_\_\_\_\_ Teacher \_\_\_\_\_

In order to provide an optimum environment, it is important that we have an understanding of your child's health status. Contact the school nurse if you wish to discuss any health problems in more detail.

Condition	Yes	No	Please explain "Yes" answers
Asthma			
Blood Transfusions			
Broken Bones			
Diabetes			
Head Injury			
Heart Condition			
Rheumatic Fever			
Fainting Spells			
Seizures			
Surgery			
Vision or Hearing Problem			
Other			
<b>Allergies:</b>			
Medication			
Food			
Environmental			

**Is he/she on medication?**

Medication (Name & Strength) Dose/Frequency Days Taken Home School

Medication (Name & Strength)	Dose/Frequency	Days Taken	Home	School

\*Is there any reason he/she can't participate in a full program, including physical education activities?

**Yes/No If yes, please explain** \_\_\_\_\_

\*Have there been any stressful events in your child's life that could have an impact on his emotional well being? Example: death or serious illness in immediate family, major economic changes, abusive behavior, recent divorce or remarriage?

**Yes/No If yes, please explain** \_\_\_\_\_

\*Has your child had chicken pox? **Yes/No If yes, when? (month/year)** \_\_\_\_\_

\*Has your child had any recent immunizations? **Yes/No If yes, please attach physician documentation.**

Please give name, address and phone number of the doctor who last examined your child.

Name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Guardian