

# SAN DIEGUITO UNION HIGH SCHOOL DISTRICT HEALTH INFORMATION FORM

\_\_\_\_\_  Male  Female \_\_\_\_\_ ID# \_\_\_\_\_

**STUDENT:** Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Initial \_\_\_\_\_ Date of Birth \_\_\_\_\_ Month/Day/ Year \_\_\_\_\_ Student Identification \_\_\_\_\_

Parent/Guardian Current Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone Number \_\_\_\_\_ Cell Number \_\_\_\_\_ Student's School \_\_\_\_\_ Grade \_\_\_\_\_

**PARENT/GUARDIAN:** The following information is necessary for the student's health record. It is required upon registration of the student. However, **if student develop new health problem/s** in the future, we request that you notify the school's Health Office **as soon as possible** to provide the appropriate care for your student. Please complete and return this form to the school's Health Office.

**MEDICATION:**

Does the student take continuing medication? NO  YES  Will it be necessary to take medication at school? NO  YES

Students are not allowed to carry medication except with physician's authorization on file for asthma and diabetes.

**All Medication:** prescribed, over-the-counter, homeopathic remedies, vitamins, etc. which are to be administered during the school day or during school-sponsored activities, require an **Authorization for Administration of Medication signed by the physician and parent. If your student requires administration of medication during school hours**, please visit the District's Web page <http://www.sduhsd.net/downloads/> to download the required form "**Authorization for Administration of Medication**" complete and personally deliver it to the school's Health Office.

**HEALTH CONDITION/S:**

Please mark the corresponding items that best describe your student's current health condition/s and return the completed form to school. Please provide specific information regarding conditions that may affect student learning and participation in school activities.

Health Condition:	Explain: (please include, date diagnosed, frequency, severity, etc.)
<input type="checkbox"/> Allergy (Serious; food, bee sting, medication, other)	_____
<input type="checkbox"/> Asthma (mild, moderate, serious)	_____
<input type="checkbox"/> Auto Immune Disease	_____
<input type="checkbox"/> Birth Defect/Genetic Disorder	_____
<input type="checkbox"/> Blood Disorder/s	_____
<input type="checkbox"/> Cerebral Palsy	_____
<input type="checkbox"/> Diabetes	_____
<input type="checkbox"/> Diagnosed ADHD/ADD	_____
<input type="checkbox"/> Emotional Disorder	_____
<input type="checkbox"/> Heart Condition	_____
<input type="checkbox"/> Migraine Headache	_____
<input type="checkbox"/> Neurological Disorder	_____
<input type="checkbox"/> Orthopedic Condition	_____
<input type="checkbox"/> Prosthesis	_____
<input type="checkbox"/> Psychological Disorder	_____
<input type="checkbox"/> Scoliosis	_____
<input type="checkbox"/> Seizure Disorder	_____
<input type="checkbox"/> <b>Other Serious Health Concerns:</b>	_____

<input type="checkbox"/> <b>Hearing Impairment</b>	<input type="checkbox"/> <b>Right Ear</b>	<input type="checkbox"/> <b>Left Ear</b>
<input type="checkbox"/> Deaf/Hard-of-Hearing	<input type="checkbox"/> Right Ear	<input type="checkbox"/> Left Ear
<input type="checkbox"/> Hearing Aids	<input type="checkbox"/> Right Ear	<input type="checkbox"/> Left Ear
<input type="checkbox"/> Hearing Problems	<input type="checkbox"/> Right Ear	<input type="checkbox"/> Left Ear
<input type="checkbox"/> <b>Visual Impairment</b>	<input type="checkbox"/> <b>Right Eye</b>	<input type="checkbox"/> <b>Left Eye</b>
<input type="checkbox"/> Student wears glasses	<input type="checkbox"/> Contact Lenses	
<input type="checkbox"/> Distance	<input type="checkbox"/> Astigmatism	
<input type="checkbox"/> Reading	<input type="checkbox"/> <b>Other:</b> _____	
<b>Date of last doctor's visit:</b> _____		

<input type="checkbox"/> <b>Speech Impairment</b>
<input type="checkbox"/> Has Had Therapy
<input type="checkbox"/> Needs Therapy
<input type="checkbox"/> <b>Physical Restrictions</b>
<input type="checkbox"/> To PE Class Participation
<input type="checkbox"/> Kind of Restrictions: _____
_____

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

**Health Office Only:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_