Rock Point School Student Health Information

To be filled out by parents and student

Student Name: _____ Date of birth: _____

Sex: _____ Gender identity: _____ Preferred pronoun: _____

Home address: _____

_____ Tel: _____

Person to contact in case of emergency if parents are unavailable

(No immediate family members, please):

Name: _____ Relationship: _____

Address: _____

_____ Tel: _____

Student's distinguishing features:

Height: _____ Weight: _____ Hair Color: _____ Eye Color:_____

Medications:

Current Medications*: _____

Why do you take them? _____

How often do you take them? _____

Past prescription medications? _____

Allergies to medications, foods, insects, etc. _____

Do you take any medications for this (antihistamines, epi pen, etc. …?) Yes No

Did you bring these to school with you? Yes No

Are there any medications you should NOT take? Why?

_____

_____

Do you get sick frequently? Yes No

What sort of illness do you usually get? _____

What do you do to feel better? _____

What are your health concerns or things you would like to be aware of?

_____

* If you need more room to write about medications, please attach additional pages.

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Student's Name _____ Date of birth _____

Do you have or have you ever had…. YES NO DATE(s) COMMENTS

Mononucleosis? _____

Chicken Pox? _____

Hepatitis? _____Type: A B C Other _____

Pneumonia? _____

Anemia? _____

Severe Headaches? _____ Migraines? _____

Dizziness/Fainting? _____

Seizures? _____

Cancer? _____

Diabetes? _____

Skin Problems? _____ Acne? Excema? Other? _____

Fractures/Sprains? _____

Surgery? _____

Hospitalizations? _____

Back Injuries? _____

High Blood Pressure? _____

Asthma? _____

Special Diet? _____

Weight Change/Eating Concerns? _____

Eating Disorders (bulimia, anorexia, etc.)? _____

Significant Anxiety/Depression? _____

Sleep Problems? _____ Insomnia? Nightmares? _____

Attention Deficit/Hyperactivity? _____

Tobacco Use? _____Cigarettes? Chewing? Vaping? _____

Alcohol Use? _____

Other Drug Use, including marijuana? (please specify) _____

Substance Abuse Treatment? _____

Dental Problems? _____ Cavities? wisdom teeth? _____

Vision Problems? Glasses Contact Lenses? _____

Date of last eye exam? _____

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Health Care Provider Information:

Name _____

Address _____

_____

Telephone _____ Fax _____

Dentist Information:

Name _____

Address _____

_____

Telephone _____ Fax _____

Psychiatrist/Therapist/Counselor Information:

Name _____

Address _____

_____

Telephone _____ Fax _____

Name _____

Address _____

_____

Telephone _____ Fax _____

Anything else you would like us to know about your health? Please attach additional page if necessary. _____

_____