

Last Name _____	First _____	M.I. _____	Birthdate _____
Teacher/Grade _____	Social Security # _____		Medicaid # _____

**Round Rock Independent School District
HEALTH SERVICES DEPARTMENT**

HEALTH INFORMATION

Dear Parent/Guardian

The information requested on this form is needed to maintain a school health record for your child. Please understand that this information may be shared with school personnel who have a need to know.

STUDENT DISEASE HISTORY

	Yes	No
Diabetes		
Asthma		
Heart Disease/Disorder		
High Blood Pressure		
Kidney Disorder		
Curvature of spine		
Blood Disorder		
Hearing Loss		
Vision Loss		

	Yes	No
Attention Deficit Disorder		
Neurological Disorder		
Arthritis		
Migraine Headaches		
Seizure Disorder		
Allergic to:		
Medication		
Food		
Other		

If you marked any of the above "Yes", please explain: _____

During the past year, has your child developed any medical condition requiring continuing medical care? (i.e. diabetes, leukemia, seizures, etc.) _____

During the past year, has your child been hospitalized? If yes, please explain _____

Is your child on any kind of medication: If so, what? _____

To be taken as school? Yes No (Circle one) ***If yes, see nurse for medication form.***

Please Note: The school nurse or any other school personnel may not give any medication without written permission from a parent or legal guardian. Any daily medication which needs to be given for longer than one month must have written permission from a physician.

All medication must be in the original container with a proper label. Prescription medication must contain the physician's name, child's name, a current date, correct dosage and directions for use. Also, the child's medication plan must be such that the medication cannot be sufficiently administered outside of school hours.

Parent/Guardian Signature

Date