

## PORTAGE TOWNSHIP SCHOOLS STUDENT HEALTH INFORMATION FORM

STUDENT'S FULL NAME: (Please Print)	GRADE:	BIRTHDATE:
PHYSICIAN:	SCHOOL:	

### Health History

Does the student have ...	Yes	No	Does the student have ...	Yes	No
ADD/ADHD			Heart Problems		
Allergies (List below)			Hypoglycemia		
Arthritis/Bone/Joint Disease			Seizures		
Asthma			Stomach/Digestive Disease		
Bladder/Bowel Problems			Vision Problems Glasses/Contacts		
Diabetes			Hearing Problems		
Emotional Concerns			Physical Handicap		
Headaches/Migraines			Other health condition not listed		

**\*\* If the answer to any of the above is YES, please explain.** \_\_\_\_\_

Does the student take medication of any kind? \_\_\_\_\_ If yes, please explain \_\_\_\_\_

\*If the student will need to take medications at school (prescription or nonprescription) a written parent consent must be on file and the PTS medication policy must be followed. See student handbook or visit online at [www.portage.k12.in.us](http://www.portage.k12.in.us) for further information. Consent forms are also available at the clinic of the school your student attends.

Has your child had chickenpox? Yes \_\_\_\_ No \_\_\_\_ If so what was the date? Month \_\_\_\_ Year \_\_\_\_

**I understand that I will be required to furnish a doctor's statement verifying the above information. I also understand that this information is CONFIDENTIAL and is being furnished for the exclusive use of the Portage Township Schools Health Services Department, and will only be released to school personnel that have direct contact with the student.**

**Completed by:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_ **Date:** \_\_\_\_\_