

## STUDENT INFORMATION

Student's Name \_\_\_\_\_ Grade \_\_\_\_\_

By furnishing us with the following information we will be better able to understand and help your student.

School attended last year? \_\_\_\_\_

Has he/she had problems with any of the following?

- |  |   |
|--|---|
| <input type="checkbox"/> Asthma  | <input type="checkbox"/> Allergies(what)                  |
| <input type="checkbox"/> Vomiting  | <input type="checkbox"/> Frequent stomach aches           |
| <input type="checkbox"/> Frequent high fevers<br>or low normal temperature | <input type="checkbox"/> Frequent headaches               |
| <input type="checkbox"/> Frequent nose bleeds                              | <input type="checkbox"/> Head injuries                    |
| <input type="checkbox"/> Attention Deficit Disorder<br>(diagnosed)         | <input type="checkbox"/> Seizures                         |
| <input type="checkbox"/> Family history of tuberculosis                    | <input type="checkbox"/> Chronic ear or throat infections |
|  | <input type="checkbox"/> Family history of diabetes       |

Please explain any serious illness, injury or hospitalization \_\_\_\_\_

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Number of brothers \_\_\_\_\_ Ages \_\_\_\_\_ School attending \_\_\_\_\_

Number of sisters \_\_\_\_\_ Ages \_\_\_\_\_ School attending \_\_\_\_\_

Any other information you wish the nurse to have.

Thank you for filling in this information.

Billie Sommers, School Nurse