Highlander Academy

Required Annual Health Status Form

School Year: **2021 - 2022**

In order to plan for your child's health care needs during school hours we need current health information. Please complete and return to the Highlander Academy office as soon as possible. Your child's health information may be shared with school staff as needed.

Student		**Grade**
Birth Date	**Age**	**Gender ☐ Male ☐ Female**

Parent/Guardian/Emergency Contacts	**Relationship**	**Phone**
Call 1st		**Home:** **Cell:**
		Work:
Call 2nd		**Home:** **Cell:**
		Work:

Student's doctor/healthcare provider: _____ Phone: _____
Student's dentist: _____ Phone: _____

INDICATE IF STUDENT HAS BEEN DIAGNOSED WITH ANY OF THE FOLLOWING:

Health Condition	**Yes**	**No**	**Explanation if "Yes"**
Severe Allergies (that require emergency medical intervention)	☐	☐	**Check type of allergy(s) that apply:**
			☐Medication ☐Food ☐Bees/Insects ☐Other
			Identify specific allergy(s):
			Does your child require an Epipen? ☐Yes ☐No
Asthma	☐	☐	**Date of last asthma attack:**
			Medication for asthma:
			Does your child need this medicine at school? ☐Yes ☐No
Diabetes	☐	☐	**☐Type 1 (Insulin Dependent) ☐Type 2 (Oral medication) or ☐ Prediabetes**
			Medication for diabetes:
			Does your child need this medicine at school? ☐Yes ☐No
Seizure Disorder	☐	☐	**Date of last seizure:**
			Medication for seizures:
			Does your child need this medicine at school? ☐Yes ☐No
Heart Condition	☐	☐	**Specify: Treatment:**
Hemophilia/Bleeding Disorder	☐	☐	**Specify: Treatment:**
Bowel/Bladder Issues	☐	☐	**Specify:**
Migraine Headaches	☐	☐	**Triggers: Treatment:**
Bone/Muscle Problems	☐	☐	**Specify: Activity Restrictions:**
ADD/ADHD	☐	☐	**Medication for ADD/ADHD:**
Wears Glasses/Contacts	☐	☐	**☐Glasses ☐Contacts → ☐For Distance ☐For Reading**
Other Serious Illness or Injury	☐	☐	**Specify: Date of Onset:**
Medication (Prescription or OTC) taken on a regular basis	☐	☐	**List (if not already listed above):**
Mental Health Behavioral Issues	☐	☐	**Specify:**
			Treatment/Medication:
Hearing Loss	☐	☐	**☐Hearing Loss Right Ear ☐Hearing Loss Left Ear**
			Does your child wear a hearing aid(s)? ☐Yes ☐No

*Please contact the school office of any change(s) in medication and/or health status of your child.

_____ _____ _____
Parent/Guardian Signature Printed Name Date