



2. Has student had any serious injuries, illnesses, accidents or been hospitalized recently? (If yes, please describe.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. Is student required to have daily medications or medical treatments during school hours? This includes asthma inhalers, breathing treatments, injections, topical creams, and oral medications. These require a medication consent form (located on RenWeb). Please list all medications and treatments below:

\_\_\_\_\_  
\_\_\_\_\_

4. Is Child Allergic to any of the following:

Foods _____	Reaction _____	Treatment _____
Medications _____	Reaction _____	Treatment _____
Insects _____	Reaction _____	Treatment _____
Chemicals _____	Reaction _____	Treatment _____
Seasonal Allergies _____	Reaction _____	Treatment _____

Treatment for any of the above requires a physician statement to be sent to school.

If medication is needed for any of the above, please complete a medication consent form found on RenWeb.

5. Health Problems: Please mark all that apply and describe the health problem(s) along with any medication or treatment needed.

- |  |   |
|--|---|
| <input type="checkbox"/> ADD/ADHD                                | <input type="checkbox"/> HEARING IMPAIRMENT               |
| <input type="checkbox"/> ASTHMA/BREATHING PROBLEMS               | <input type="checkbox"/> HEMOPHILIA/BLEEDING DISORDER     |
| <input type="checkbox"/> BOWEL/INTESTINAL PROBLEMS               | <input type="checkbox"/> HYPERTENSION/HIGH BLOOD PRESSURE |
| <input type="checkbox"/> CARDIAC/HEART PROBLEMS                  | <input type="checkbox"/> NEUROLOGICAL/BIRTH DEFECT        |
| <input type="checkbox"/> CANCER/LEUKEMIA                         | <input type="checkbox"/> PHYSICAL IMPAIRMENT              |
| <input type="checkbox"/> DENTAL PROBLEMS                         | <input type="checkbox"/> SKIN DISORDERS                   |
| <input type="checkbox"/> DIABETES/HYPOGLYCEMIA                   | <input type="checkbox"/> STOMACH PROBLEMS/ULCERS          |
| <input type="checkbox"/> EPILEPSY/SEIZURES/CONVULSIONS           | <input type="checkbox"/> URINARY/KIDNEY/BLADDER PROBLEMS  |
| <input type="checkbox"/> HEADACHES-frequent requiring medication | <input type="checkbox"/> VISION PROBLEMS                  |
| <input type="checkbox"/> HEADACHES-migraine                      | <input type="checkbox"/> OTHER PROBLEMS                   |
| <input type="checkbox"/> HEADACHES-sinus                         |   |

Explanation of health problems marked above: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does student have any limitations that prevent him/her from participating in physical education or school sponsored activities? If so, please describe and send a physician statement regarding limitations: \_\_\_\_\_

I give consent for my child to receive first aid at school for minor injuries, insect bites or small accidents that occur. Injuries will be cleaned with soap and water. At times, hydrogen peroxide, antibiotic ointment and anti-itch creams may be used if necessary.

\_\_\_\_\_  
Parents signature

\_\_\_\_\_  
Date

