Santa Paula Unified School District
Student Health Record
2019 - 2020

Please complete the following information.

Student Name: _____Grade: _____ School: _____

Date of Birth: _____ Place of Birth: _____ Gender: ___M ___F

Parent/Guardian Name: _____

Parent/Guardian Home Phone #:_____ Cell #: _____

Parent/Guardian Email: _____

Siblings and name of schools attending: _____

Medical Information: Check all that apply:

- ☐ Anorexia
- ☐ Anxiety
- ☐ Asthma
- ☐ Autism/Asperger
- ☐ ADD
- ☐ ADHD
- ☐ Bipolar Disorder
- ☐ Bulimia
- ☐ Cerebral Palsy
- ☐ Concussion
- ☐ Depression
- ☐ Diabetes (*Type I / II)*
- ☐ Ear Infections
- ☐ Headaches/Migraines
- ☐ Heart Condition
- ☐ High Blood Pressure
- ☐ Mental Health Conditions
- ☐ Nose Bleeds
- ☐ Scoliosis
- ☐ Seizure Disorder
- ☐ Skin Condition
- ☐ Speech Condition
- ☐ Tonsillitis/Strep Throat
- ☐ Vision Problems (*Glasses:* ____)
- ☐ Hearing Problems (*Hearing Aid:* _____)
- ☐ Physical Limitations or PE Restrictions
- ☐ 504 Plan
- ☐ IEP

Other: _____

Allergies:

- ☐ Medication: _____ Requires Benadryl or Epi-Pen: _____
- ☐ Food: _____ Requires Benadryl or Epi-Pen: _____
- ☐ Bee stings Requires Benadryl or Epi-Pen: _____
- ☐ Environmental (grass, pollen, pets…) Requires Benadryl or Epi-Pen: _____

List ALL medications your child routinely takes:

_____

(If medication is to be administered at school, a Medication Administration form MUST be filled out by the child's physician and medication MUST be brought in the original container.)

Doctor/Clinic Name: _____ Phone #: _____

Parent/Guardian Signature: _____ Date: _____