

## FRANKLIN REGIONAL SCHOOL DISTRICT STUDENT HEALTH NEEDS IDENTIFICATION FORM

NAME \_\_\_\_\_ GR \_\_\_\_\_ DOB \_\_\_\_\_ SEX \_\_\_\_\_

HOME PHONE \_\_\_\_\_ ALTERNATE PHONE \_\_\_\_\_

**MEDICAL HISTORY:** PLEASE CHECK IF YOUR CHILD HAS NOW OR IN THE PAST.

	NOW	PAST		NOW	PAST
Allergic reaction requiring Emergency treatment			Asthma – treated with medication		
Diabetes			Seizures/Epilepsy		
Heart problems			Bone or joint problems		
Vision problems			Hearing problems		
Migraine headaches			Stomach problems		
Skin disease			Bladder/Kidney problems		
Respiratory problems			Cancer		
Blood disorders/anemia			ADD/ADHD		
Other:			Other:		
<b>Serious Accidents:</b>			<b>Operations:</b>		
Wheelchair	Walker		Glasses	Hearing Aide	Speech Difficulty

CHICKENPOX DISEASE: M \_\_\_\_\_ YR \_\_\_\_\_ VACCINE: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**PLEASE LIST ANY OTHER MEDICAL PROBLEMS NOT MENTIONED ABOVE:**

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**LIST ANY SERIOUS ILLNESS OR INJURIES:**

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**LIST ANY MEDICAL PROCEDURES THAT MUST BE PERFORMED AT SCHOOL:**

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**LIST ANY MEDICATIONS THAT MUST BE GIVEN AT SCHOOL (MEDICATIONS CANNOT BE ADMINISTERED UNTIL THE PROPER FORMS HAVE BEEN COMPLETED FOR EACH MEDICATION):**

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2/04 PARENT/GUARDIAN SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_