Franklin Regional School District
Student Health Identification Form

NAME____________________________GRADE_____DOB__________SEX____

HOME PHONE___________________ALTERNATE PHONE______________________

MEDICAL HISTORY: PLEASE CHECK IF YOUR CHLD 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 disorder/anemia			ADD/ADHD		
Other			Other		
Serious Accidents			Operations		

Wheelchair	Walker	Glasses	Hearing Aide	Speech Difficulty	

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 MEDICATON):

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Parent/Guardian Signature____________________________________Date______________