St. Johns Lutheran School
Student Health Form

Name:		**Date of Birth:** / /
(Last)	*(First)*	*(Middle)*
Student's Physician:	**Name:** **Phone Number:**	
Student's Dentist:	**Name:** **Phone Number:**	
Does your child have allergies?	**Yes / No**	**If yes, please list allergy and any medication required:**
Does your child have reactions to insect bites?	**Yes / No**	**If yes, please list reaction and any medication required:**
Does your child have asthma?	**Yes / No**	**If yes, please list medications taken as needed:**
List any prescription or over-the-counter medications your child takes frequently/ routinely/or during school hours:		
Does your child have special activity needs or restrictions?	**Yes / No**	**If yes, please list:**
Does your child have chronic illnesses?	**Yes / No**	**If yes, please list:**
Does your child have (circle all that apply):	**Glasses Contacts Retainer Hearing Aid Dental Braces**	
Does your child have any other illnesses, injuries, emotional, behavioral, or health concerns you feel the school will need to know:		
I hereby give my permission for St. Johns Lutheran School to act in an emergency situation if I cannot be reached. **Parent Signature:**		**Date:**

911 will be called in the event of an emergency.

Chronic Condition Emergency Procedure:

My child, _____, has _____, which could require emergency medication and/or care. Please discuss this procedure with your child and your physician so that you all understand and agree about what will happen in the event of an emergency. List in order the sequence of things that should be done for your child (i.e., call 911, give Epi-pen, call parents, give other medications, apply ice pack, etc.):

1._____

2._____

3._____

4._____

5._____

I request that the above procedure be followed for my child.