



IUUSD HEALTH SERVICES
HEALTH CONDITION INFORMATION

Student's Last Name: _____ Student's First Name: _____ Date of Birth: _____ Gender: Male Female Grade: _____
 Does this student have health insurance? Yes No

Physician's Name: _____ Physician's Phone Number: _____
 If no, would you be interested in receiving information about possible health insurance options? Yes No

Does this student have any difficulty with vision? Yes No
 If yes, corrective lenses are worn for: Distance Close work Both
 Does this student wear glasses or contact lenses? Yes No
 Comments: _____

Does this student have a hearing loss? Yes No
 Does this student wear a hearing aid? Yes, right ear Yes, left ear Yes, both ears No
 If yes, the hearing loss is in the: right ear left ear both ears
 Comments: _____

Has this student been diagnosed with or treated for ANY medical conditions? Yes No
 If yes, please list and describe or explain the medical condition(s): _____

Could any of these conditions affect this student's ability to participate in routine school activities or programs, either in the classroom or during physical activity: Yes No
 Please list and explain any medical restrictions, considerations, or special needs: _____

Does this student require any special health procedures during the regular school day? Yes No
 If yes, please list the procedures and any equipment that will be needed: _____

Does this student take any prescription or non-prescription medication, either regularly or occasionally, at home or at school? Yes No If yes, please complete the following:

Medication: _____	Dose/time/frequency given: _____	Reason for medication: _____	Needed: <input type="checkbox"/> at home <input type="checkbox"/> at school <input type="checkbox"/> both
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Please note that any prescription or non-prescription medication needed at school requires a written physician order and parental consent. Medication forms are available on line at www.iusd.org.

Provide any additional information that could impact this student's health, safety, or education: _____

Please remember that any student's education can be affected by medical, developmental, or emotional conditions and it is a parent/guardian responsibility to immediately notify the school nurse of any changes in the student's health status.

By signing below, you are affirming that the above statements are true to the best of your knowledge and giving permission for school personnel to contact the physician if needed.

Parent/Guardian Signature: _____	Relationship to student: _____	Best way to reach me: Phone: _____	Email: _____
Parent/Guardian Signature: _____	Relationship to student: _____	Best way to reach me: Phone: _____	Email: _____