

# HEALTH INFORMATION

## Rosemont Ridge Middle School Student Information:

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

DOB \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_

Phone Numbers: Home \_\_\_\_\_ Cell \_\_\_\_\_

Please complete this form providing current student health information and return to your student's school as soon as possible. It is the responsibility of the parent to provide health information, special food needs, and medications in school. If you have any questions, please call the District Nurse @ 503-673-7021

**ALLERGY:** \_\_NO\_\_YES. Describe to what: \_\_\_\_\_

Every had an anaphylactic reaction \_\_No\_\_Yes.  
Describe: \_\_\_\_\_

**ASTHMA**\_\_NO\_\_YES

Does Asthma limit any school activity? \_\_No\_\_Yes.  
Describe: \_\_\_\_\_

Daily Medication needed at school? \_\_No\_\_Yes. List: \_\_\_\_\_

**SEIZURES:** \_\_NO\_\_YES

Last seizure \_\_\_\_\_ Medication needed at school \_\_No\_\_Yes  
List: \_\_\_\_\_

**DIABETES:** \_\_NO\_\_YES Describe \_\_\_\_\_

Insulin needed at school \_\_No\_\_Yes

If yes, \_\_pen\_\_pump

**OTHER MEDICALLY VERIFIABLE ISSUES:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### School Use Only:

School: \_\_\_\_\_ School Year \_\_\_\_\_

If Parent has answered yes to any of the questions please return to Brenda Hogan in Nursing Services ASAP

[Hoganb@wlwv.k12.or.us](mailto:Hoganb@wlwv.k12.or.us)

Fax Number 503-673-7003