PUPIL MEDICAL RECORD
Confidential Information

STUDENT ID#	SCHOOL

Student Name: ____________ Birthdate: ____________ Grade: ____________ Sex: M F

Parent/Guardian: ____________ Work PH: ____________ Home PH: ____________

Email: ____________ Cell PH: ____________

Name of Healthcare Provider/Clinic: ____________ Phone: ____________

GUARDIAN'S EVALUATION OF STUDENT'S HEALTH

1. Has your student been **diagnosed by a healthcare provider** for any of the following? **If yes, please describe.**

- ❑ ADD/ADHD ____________
- ❑ Allergy to: ____________
  Is Epinephrine prescribed: ☐ Yes ☐ No
  Note: An additional form must be completed by a healthcare provider when Epinephrine is prescribed.
- ❑ Asthma ____________
  Note: An additional form must be completed by a healthcare provider when student is diagnosed with Asthma.
- ❑ Bladder Disorder ____________
- ❑ Blood Disorder ____________
- ❑ Bowel Disorder ____________
- ❑ Cancer *Date:* ____________
- ❑ Concussion/Head Injury *Date:* ____________
- ❑ Diabetes ☐ Type 1 ☐ Type 2 *Date of diagnosis:* ____________
- ❑ Ear Disorder ____________
- ❑ Eye Disorder ____________
- ❑ Food Intolerance to: ____________
- ❑ Heart Condition ____________
  Has this condition been repaired? ☐ Yes ☐ No *Date of repair*: ____________
- ❑ Seizure Disorder ____________
- ❑ Suppressed Immune System ____________
- ❑ Syndrome *Date of diagnosis:* ____________
  Describe: ____________
- ❑ Other health problem *Date of diagnosis:* ____________
  Describe: ____________

2. Does your student have a physical handicap? ☐ Yes ☐ No *Describe:* ____________
3. Has your student ever had an operation? ☐ Yes ☐ No *Describe:* ____________
4. Has your student ever had a severe injury? ☐ Yes ☐ No *Describe:* ____________
5. Is your student presently under a healthcare provider's care for a particular illness or condition? ☐ Yes ☐ No
   State nature of illness or condition: ____________
6. Is he/she taking medication? ☐ Yes ☐ No *Reason:* ____________
   Name of medication: ____________
   Note: An additional form must be completed for all medications taken at school
7. Is your student able to participate in full activity at school? ☐ Yes ☐ No
   Note: An additional form must be completed by a healthcare provider when Yes is checked for activity restrictions.
8. Has your student been hospitalized recently? ☐ Yes ☐ No *Date:* ____________ *Reason:* ____________

PLEASE CALL THE NURSE HELPLINE AT (503)399-3376 IF YOU HAVE FURTHER QUESTIONS OR CONCERNS

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SIGNATURE OF PARENT/LEGAL GUARDIAN **DATE**