

ADAMS-FRIENDSHIP AREA SCHOOL DISTRICT 2025-2026 STUDENT HEALTH INFORMATION

STUDENT FULL LEGAL NAME : _____
DATE OF BIRTH : ____/____/_____
GRADE : _____
PARENT/GUARDIAN NAME : _____
PARENT/GUARDIAN PHONE # () _____
PARENT/GUARDIAN NAME : _____
PARENT/GUARDIAN PHONE # () _____
PHYSICIAN : _____ PHYSICIAN PHONE # () _____

☐ **My child does not have any health concerns requiring monitoring, care, or treatment at school.**

Please sign here if your child does NOT have health concerns : _____

Date: _____

The parent/guardian is responsible for providing the school with any medications, treatments, or equipment that the student will require during the school day. The parent/guardian is responsible for providing the school with the necessary medical information, appropriate authorization forms, and written consent prior to any medications or treatments in school.

SEVERE ALLERGIES

Bee Sting Allergy requiring treatment

- ☐ **EpiPen**
- ☐ **Antihistamine**
- ☐ **Other** _____

Food Allergy requiring treatment list food(s) _____

- ☐ **EpiPen**
- ☐ **Antihistamine**
- ☐ **Avoid**
- ☐ **Other** _____

Paperwork required for treatment

ALLERGIES

Environmental allergy list allergen(s) _____

- ☐ **EpiPen**
- ☐ **Antihistamine**
- ☐ **Avoid**
- ☐ **Other** _____

Medication allergy list medication(s) _____

Paperwork required for treatment

Asthma ☐ YES ☐ NO

Medication needed in school for asthma? YES____ NO____

Paperwork required for treatment

DIABETES ☐ YES ☐ No

Please request a school health office appointment to discuss your child's diabetic care prior to the beginning of the school year by emailing AFASDnurse@afasd.net or by calling your child's school and dialing extension 1111 at the prompt.

DIAGNOSED MENTAL/EMOTIONAL HEALTH

ADHD
Anxiety
Depression
PTSD
Autism
ODD
Other : _____

Medication needed for **this** condition in school? YES___ NO___

Does the student attend counseling? YES___ NO___

History of hospitalization related to mental/emotional health YES___ NO___

SEIZURE DISORDER

☐ YES ☐ No

Medication needed in school for seizures? YES___ NO___

Date of last seizure:_____ Length of seizures:_____ Frequency of seizures:_____

Please request a school health office appointment to discuss your child's seizure care prior to the beginning of the school year by emailing AFASDnurse@afasd.net or by calling your child's school and dialing extension 1111 at the prompt.

VISION CONDITIONS

☐ Contacts ☐ Glasses

Date of last exam:_____

HEARING CONDITIONS

Hearing aid(s) Right Left Both

Date of last exam:_____

FOOD INTOLERANCE

☐ Cultural, Personal, or Religious Preference
☐ Digestive distress caused by food

List foods child cannot have:

[Paperwork required for alternative food options](#)

DENTAL CONDITIONS

☐ Braces/Orthodontic Appliances/Retainers
☐ Decay/pain

Date of last exam:_____

[Sign up for the Seal-a-Smile Program](#)

PHYSICAL EDUCATION CLASS PARTICIPATION

Does your student have a documented condition that prohibits them from participating in a Physical Education class?
YES___ NO___ If yes, explain : _____

*****A healthcare providers order may need to be obtained in order to excuse a student from physical education class*****

