SCHOOL DISTRICT OF NIAGARA STUDENT HEALTH INFORMATION 2025 – 2026

The following health information is confidential, but pertinent health information may be shared with school staff on a need-to-know basis to provide the best care for your child. If you do not want health information shared, you must provide a written request.

STUDENT NAME: _____ GRADE: _____

Please see the school nurse for any items marked "yes" in the following questions 1-5.

1. **ALLERGIES**

_____**YES** **FOOD: What type of food?** _____

Medication needed to treat reaction at school? **Yes**_____**(CALL/SEE NURSE)** **No**_____

Type of Medication: EPI-PEN _____ Antihistamine _____ Other _____

_____**YES** **Bee/Wasp Sting:**
Medication needed to treat reaction at school? **Yes**_____**(CALL/SEE NURSE)** **No**_____

Type of Medication: EPI-PEN _____ Antihistamine _____ Other _____

_____**YES** **Other Allergies**: Please List: _____
Medication needed at school for symptoms? **Yes**_____**(CALL/SEE NURSE)** **No**_____

2. **ASTHMA**

_____**YES** Asthma triggers: _____

Medication needed to treat symptoms at school? **Yes**_____**(CALL/SEE NURSE)** **No**_____

Inhaler _____ Nebulizer _____ Other _____

3. **DIABETES**

_____**YES** **Call/See Nurse**
Medication taken at school: Insulin _____ Oral _____

4. **SEIZURE DISORDER**

_____**YES** **Call/See Nurse**
Medication taken at school: _____

5. **Does your child have any other health conditions/concerns the school should be aware of**?

_____**YES** _____ **NO** **If yes, please list medical condition or health/other concerns:**

_____

_____

Please list routine daily medications your child will need to take during the school day:

Medication _____ Time _____(Contact the school nurse)

Does your child wear: Glasses? _____ Contacts? _____

I give my child permission to participate in hearing/vision screening: Yes_____ No_____

Any other information you feel would be helpful to school personnel in caring for your child at school:

_____

_____

If emergency care is required, and no one can be reached, may the school authorities use their judgment in caring for your child? Yes_____ No_____ If no, indicate plan to follow: _____

_____

Your signature gives the school personnel and hospital permission to provide first aid/other medical/emergency care, and is intended for use throughout this school year. Please notify the school personnel of any changes by calling 715-251-4541.

_____ _____

Parent/Guardian Signature **Date**