MIFFLIN COUNTY SCHOOL DISTRICT
Health Information Form

Name of School_____ Current Grade: _____
Student's Name _____
Last First Middle
Student's Date of Birth_____/_____/_____ Sex: _____
Student's Address _____City _____ State _____ Zip _____
Name of Mother or Legal Guardian _____ Phone _____ Work or Cell _____
Name of Father or Legal Guardian _____ Phone _____Work or Cell _____
Emergency Contact_____ Phone _____Work or Cell_____

Condition	Yes	Comments	Condition	Yes	Comments
Allergies (food, insects, drugs, latex)			Diabetes		
Allergies (seasonal)			Head Injury, Concussions		
Asthma or Breathing Problems			Hearing Problem or Deafness		
Attention-Deficit/Hyperactivity Disorder			Heart Problems		
Behavioral Problems			Lead Poisoning		
Developmental Problems			Muscle Problems		
Bladder Problems			Seizures		
Bleeding Problems			Sickle Cell Disease (Not Trait)		
Bowel Problems			Speech Problem		
Cerebral Palsy			Spinal Injury		
Cystic Fibrosis			Surgery		
Dental Problems			Vision Problems		

Describe any other important health-related information about your child (for example, feeding tube, hospitalizations, oxygen support, hearing aid, etc.) _____

List all Prescription, over-the-counter, and herbal medications your child takes regularly:
_____

Please provide the following information:

	Name	Phone	Date of Last Appointment
Pediatrician/Primary Care Provider			
Specialist			
Dentist			

I, _____ (do) (do not) authorize my child's health care provider and designated provider of health care in the school setting to discuss my child's health concerns and/or exchange information pertaining to this. This authorization will be in place through the end of the 2025-26 school year. You may withdraw your authorization at any time by contacting your child's school. When information is released from your child's records, documentation of the disclosure is maintained in your child's health or scholastic record.

Signature of Parent or Legal Guardian _____ Date _____/_____/_____

_____ _____
Parent/Guardian Signature Date