Emergency contact:
_____

Contact Number:
_____

JEFF TECH

576 VO TECH ROAD
REYNOLDSVILLE, PENNSYLVANIA 15851-6368
(814) 653-8265
FAX: (814) 653-8425

Student Health History Form 2026-2027

Dear Parent/Guardian,

To ensure proper medical treatment at school, we rely on you to keep the school informed of new developments regarding your child's health. Please take time to complete the front and back of this form and provide signatures where requested, so we have current health information in your child's file for this school year.

Student's Name: _____Grade: _____ Shop: _____

Does your child require treatment for any of the following conditions? Please circle:

- **Asthma**: YES or NO
  - Inhaler:_____
  - Does your child need to self-carry their inhaler? YES or NO
- **Bee Stings**: YES or NO
  - Benadryl or Epi-Pen
  - Does your child need to self-carry their Epi-Pen? YES or NO
- **Life Threatening Allergy**: YES or NO
  - What is your child's allergy? _____
  - What are their reaction symptoms? _____
  - Treatment: _____
- **Milk Allergy**: YES or NO
- **Seizures**: YES or NO
  - Type: _____
  - Treatment: _____
  - Last known seizure: _____
- **Cardiovascular disease:** YES or NO
  - Diagnosis: _____
- **Bleeding Disorder:** YES or NO
  - Diagnosis: _____

Health Conditions	Specify/Explain/Treatment
Arthritis/Joint Disorder/Lymes	
Bowel/Gastrointestinal Problem	
Brain/CNS Disorder	
Cancer	
Infection Disease (i.e. Chicken Pox, Measles)	
Diabetes	
Drug Allergies	
Environmental/Seasonal Allergies	
Genetic Disorder	

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Headaches/Migraines	
Hearing Impairment: RIGHT/LEFT/BOTH	Hearing Aid?
Heart Murmur	
Kidney/Urinary Disorder	
Mental Health Disorder (i.e. ADD/ADHD, autism, Depression, Anorexia)	
Orthopedic Disorder	
Skin Disease	
Visual Impairment: RIGHT/LEFT/BOTH	Contacts/ Glasses?
Other (Please Specify)	

Medications:

- Please list all medication the student takes on a regular/daily basis:
  - _____
- Does your child need to take medication during the school day (i.e. Epi-Pen, inhaler, daily medication)?
  - _____

The school nurse, or other designee approved by the school administrator, has my permission to administer the following medications as prescribed by the school physician to my child. Please **initial** by each medication, and **circle** the dosage you would like your child to receive.

_____ Ibuprofen (Motrin) 200mg or 400mg

_____ Antacid (Tums) 1 tab or 2 tab

_____ Cough Drops

_____ Epi-Pen

_____ Acetaminophen (Tylenol) 325 mg or 650mg

_____ Benadryl 25 mg or 50 mg

_____ Orajel

Parent/ Guardian Signature: _____ Date: _____

I authorize school personnel to obtain emergency medical care for my child in the event I cannot be reached. If transportation by ambulance is required, this may be obtained.

Parent/ Guardian Signature: _____Date: _____

For the health, safety and welfare of your child, appropriate information may need to be shared with your child's teachers and staff as needed. Do you agree to the sharing of this information?

Please **circle**: YES or NO

Parent/ Guardian Signature: _____Date: _____

Emergency contact:

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