



Poway Unified School District
15250 Avenue of Science, San Diego CA 92128

Health Services Student Health Information

STUDENT: _____ M F BIRTHDATE: _____
 SCHOOL: _____ GRADE: _____

PARENT/GUARDIAN: Please **CIRCLE** the appropriate number(s) that best describes your student's current health condition(s) and return completed form to school. Please provide specific information regarding conditions that may affect student learning and participation in school activities.

MEDICATION: All medication (prescription, over-the-counter, homeopathic remedies, vitamins, etc.), which *is to be administered during the school day or during school-sponsored activities*, requires an Authorization for Medication Administration (H-26) to be completed and signed by physician and parent. Students are not allowed to carry medication without an Authorization to Carry Medication (H-26B) on file. Both medication forms may be found on the PUSD Health Services website. Submit completed medication form to school Health Technician and any school sponsored activity your student may attend.

| Number | Health Condition | Specific Information | |
|---|--|---|---|
| 009 | ADD/ADHD | Medication: | (032) |
| 202 | Allergy- Serious -Bee/Insect | Medication: | (232) |
| 203 | Allergy- Serious -Food | Medication: | (232) |
| 204 | Allergy- Serious -Medication | Medication: | (232) |
| 205 | Allergy- Serious -Other (animal, latex, etc.) | Medication: | (232) |
| 007 | Asthma-Mild to Moderate | Medication: | (032) |
| 207 | Asthma- Serious | Medication: | (232) |
| 022 | Birth Defect/Genetic Disorder | Description: | |
| 227 | Blood Disorders (Chronic) | | |
| 215 | Diabetes – Insulin Dependent | | |
| 020 | Emotional/Psychological/Eating Disorder | | |
| 023 | Hearing Problems (infections, tubes, nerve damage, etc.) | | |
| 024 | Deaf/Hard-of-Hearing | Right Ear <input type="checkbox"/> Left Ear <input type="checkbox"/> | |
| 025 | Hearing Aids | Right Ear <input type="checkbox"/> Left Ear <input type="checkbox"/> | |
| 026 | Heart Problems – No restrictions | | |
| 226 | Heart Problems – Restrictions: | | |
| 032 | Medication – Long Term | | |
| 033 | Migraine Headache | Medication: | (032) |
| 042 | Orthopedic Condition | Description: | |
| 046 | Prosthesis | | |
| 045 | Scoliosis | | |
| 237 | Seizure Disorder – Type: | Medication: | (032) |
| 054 | Visual Impairment | Right Eye <input type="checkbox"/> Left Eye <input type="checkbox"/> | |
| 052 | Glasses/contact lens | Distance <input type="checkbox"/> Reading <input type="checkbox"/> | |
| 055 | Color Deficient/Color Blind | | |
| 256 | OTHER SERIOUS ILLNESS/INJURY/ HEALTH CONCERN (LIFE THREATENING) | Description: | |
| 056 | OTHER ILLNESS/INJURY/HEALTH CONCERN (NON-EMERGENCY) | Description: | |
| 000 | NO HEALTH CONCERNS AT THIS TIME | | |
| New Students Only! | | Has your student ever attended a California Public School (including Transitional Kindergarten or Kindergarten)? | <input type="checkbox"/> Y <input type="checkbox"/> N |
| If “Yes” name <u>one</u> California School or School District attended. | | | |

Parent/Guardian Signature

Date