

STUDENT HEALTH INFORMATION

Student's Name: _____ Sex: _____ Birth Date: _____ Grade: _____

Parent/Guardian: _____

Home Phone: _____ Cell Phone: _____ Email Address: _____

Student lives with: ☐ both parents ☐ Mother ☐ Father ☐ Other _____

MEDICAL HISTORY

Family Healthcare Provider/Clinic: _____ Phone: _____

Current Medical Diagnosis (if any): _____

YES	NO	Does your student have:
<input type="checkbox"/>	<input type="checkbox"/>	Food or insect bite allergies (type and severity) _____
<input type="checkbox"/>	<input type="checkbox"/>	Asthma or other respiratory condition (type and severity) _____
<input type="checkbox"/>	<input type="checkbox"/>	ADD/ADHD/Autism (type and severity) _____
<input type="checkbox"/>	<input type="checkbox"/>	Bone disease/deformity _____
<input type="checkbox"/>	<input type="checkbox"/>	Heart condition or murmur (list any activity limitations) _____
<input type="checkbox"/>	<input type="checkbox"/>	Kidney condition/ disorder _____
<input type="checkbox"/>	<input type="checkbox"/>	Cancer/blood disorder _____
<input type="checkbox"/>	<input type="checkbox"/>	Neuro/muscular disorder _____
<input type="checkbox"/>	<input type="checkbox"/>	Skin condition _____
<input type="checkbox"/>	<input type="checkbox"/>	Stomach/bowel condition _____
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes _____
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/Seizures (list type and frequency) _____
<input type="checkbox"/>	<input type="checkbox"/>	Immune system disorder _____
<input type="checkbox"/>	<input type="checkbox"/>	Mental health disorder _____
<input type="checkbox"/>	<input type="checkbox"/>	Has your child had the Chickenpox disease? (if yes, what age) _____
<input type="checkbox"/>	<input type="checkbox"/>	Serious accident or injury _____
<input type="checkbox"/>	<input type="checkbox"/>	Vision Exam? Date _____ By Whom _____ Results _____
<input type="checkbox"/>	<input type="checkbox"/>	Any other health concerns that you would like the school nurse to know about? _____

MEDICATION

Does your student need to take any medications while at school? ☐ Yes ☐ No

If yes, what type(s) and reason: _____

*All medications (with the exception of asthma inhalers, epi-pens, and diabetes medications) must be kept in the office and administered by staff. A Medication Authorization Form signed by your healthcare provider is required before we can administer any medications. *Note: Students may have and self-administer asthma inhalers, epinephrine pens, and diabetes medications at school, however we need to have a form on file signed by your healthcare provider. These forms are available in the office and need to be updated each school year.*

Signature of Parent/Guardian _____

Date _____

CHILD NUTRITION

Dear Parent:

Information about each new kindergartner, needed for matching to older siblings' current meal benefits during the first 30 operational days of the school year (pending reapplication for those wanting to apply for Free/Reduced meals). Applications for Free/Reduced meals for the 2017-18 will be available after mid July in 2017. After this date you can also fill out an application on line at: schoollunchapp.com

(Español)

Estimados Padres:

El Distrito Escolar de Provo le extenderá 30 días de comidas gratis o a precio reducido a su nuevo estudiante de Kindergarten, si su familia califico para tal, mientras se procesa su nueva solicitud. Favor de proveer la siguiente información. Las aplicaciones para comidas gratis o a precio reducido para el año escolar 2017-18 estarán disponibles después del mediado de Julio del 2017. Después de esta fecha también pueden aplicar por internet en: schoollunchapp.com

1) Kindergartner's full name _____

Nombre del niño(a) que entrara al kindergarten

2) Parents' names _____

Nombre de los Padres

3) Siblings' names that go to Provo School District

Nombre de los hermano(a)s que asisten en las escuelas del Distrito Escolar de Provo

_____	School: _____
_____	School: _____
_____	School: _____
_____	School: _____
_____	School: _____
_____	School: _____
_____	School: _____

Thank you
Gracias

SCHOOL REGISTRAR: These forms are to be sent to the Child Nutrition Department.