FOR STUDENTS WITH
CHRONIC HEALTH CONDITIONS
EG: ASTHMA

THE SCHOOL DISTRICT OF PHILADELPHIA
SCHOOL HEALTH SERVICES

STUDENT HEALTH STATUS

LAST NAME		FIRST NAME	BIRTH DATE
SCHOOL NAME	ROOM/BOOK	GRADE	DATE OF ISSUE

Please complete this form and return it to your school nurse immediately for the safe care of your child.

To Parent/Guardian:

Your child's health record/history indicates that he/she has been under care for the following health problem(s):

____

1. Does the student's health problem(s) still exist? _______________

2. Does he/she have other health problems? Yes ☐ No ☐ If yes, what are they? _______________

3. Does he/she take medicine?
   Yes ☐ No ☐
   If yes, please give name of medicine, dosage, and time(s).

Medicine	Dosage	Time

4. Does he/she regularly receive treatment/therapy or undergo any testing procedures? _______________
   If yes, please indicate kind and how often taken _______________

5. Name of doctor, clinic or health center providing care for the student _______________
   Address _______________
   Phone # _______________ Fax # _______________ Date of last visit _______________
6. Insurance Provider _______________

CONTACTS:

Parent/Guardian: _______________ Home Phone: _______________
Work Phone: _______________ Cell/Pager: _______________
Parent/Guardian: _______________ Home Phone: _______________
Work Phone: _______________ Cell/Pager: _______________
Emergency Contact #1: _______________ Phone # : _______________
Emergency Contact #2: _______________ Phone # : _______________

I authorize the school nurse to communicate with my child's health care provider and my health care provider to reply as needed regarding my child's care.

Parent/Guardian _______________ Date _______________

TO SCHOOL STAFF: SEE REVERSE SIDE FOR EMERGENCY CARE

SCHOOL NURSE	PHONE #

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