



Whiteford Agricultural School District

Health Information Survey

Student Last Name _____ First Name _____ Gender _____

Date of Birth _____ Grade _____ School Attending _____ School Year _____

Please note any physical or personal problems for which the student might require special attention or help from school personnel (e.g., severe allergies, asthma, mental health issues, etc.).

My child's health concerns include:

- Asthma
- Diabetes
- Seizures
- Severe food allergy
- Severe stinging insect allergy
- Heart condition
- Other _____

Medication(s):

If your child does have a medical concern, the building office will contact you to obtain more information as needed to plan for the upcoming school year.

Parent/Guardian Name (please print) _____ Parent/Guardian Signature _____

Date _____ Best Contact Phone Number _____

Email Address _____

This form is not a medication authorization form. If your student will or may require medication at school, please complete the **PRESCRIBED MEDICATION** form.