Alachua County Public Schools
Health Services Department
Health Condition

Student Name:_____ DOB:_____ School:_____ Grade:_____

The health condition/s listed below are noted on your child's school health record. Please review the condition/s listed and note any corrections or changes in the area provided. Please return this form to your child's school nurse so that records can be updated as soon as possible.

Conditions on your student's health records (If student has asthma or allergy see below)	**DOES** have this condition	**DOES NOT** have this condition
1.		
2.		
3.		

ASTHMA: ☐ No ☐ Yes (if yes, fill out the next 4 questions)

1. Does the student take medication for Asthma at home daily? ☐ Yes ☐ No
2. Does the student have a rescue inhaler? ☐ Yes ☐ No
3. How frequently does the student use their inhaler? _____ (daily, weekly, etc.)
4. How long ago was the student's last asthma attack? _____

ALLERGY:

*Your student is listed as allergic to: _____

1. Symptoms of allergy? _____
2. Do they carry an EpiPen for this allergy? ☐ Yes ☐ No

Parent/Guardian Name (printed)_____

Parent/Guardian Signature:_____ Date:_____

If you have any questions please contact your school nurse.

<u>PLEASE RETURN</u> THIS TO THE SCHOOL NURSE FOR RECORDS TO BE UPDATED.