Silver Falls School District 4J

Code: **JHCA-AR**
Adopted: 4/10/94-E
Readopted: 9/8/97

Silver Falls School District Pupil Health Record

Student's name _____ Sex M F Birth date _____
mo./day/year

Name of school _____ Grade _____

==========

Circle the following that your child has now or has had in the past:

Blood disorders	Yes	No	Year___	Heart condition	Yes	No	Year__
Kidney disorders	Yes	No	Year___	Asthma	Yes	No	Year___
Lead poisoning	Yes	No	Year___	Orthopedic impairments	Yes	No	Year___
Concussion	Yes	No	Year___	Operations	Yes	No	Year___
Skull fractures	Yes	No	Year___	Exposure to tuberculosis	Yes	No	Year___
Neck injuries	Yes	No	Year___	Rubella (3-day measles)	Yes	No	Year___
Back injuries	Yes	No	Year___	Rubeola (7-day measles)	Yes	No	Year___
Muscle, bone,				Mumps	Yes	No	Year___
joint diseases	Yes	No	Year___	Rheumatic fever	Yes	No	Year___
Skin disorders	Yes	No	Year___	Scarlet fever	Yes	No	Year___
Eye glasses	Yes	No	Year___	Chicken pox	Yes	No	Year___
Contact lenses	Yes	No	Year___	Urinary tract infections	Yes	No	Year___
Visual treatments	Yes	No	Year___	Urinary tract disorder	Yes	No	Year___
Treatment underway	Yes	No	Year__	Allergies: (circle)			
Hearing treatments	Yes	No	Year___	Insect stings	Food		
Treatment underway	Yes	No	Year__	Pollens	Medicines		
Hernia	Yes	No	Year___	Dust	Other_____		
Diabetes	Yes	No	Year___	Currently on long-term			
Seizure disorder	Yes	No	Year___	medication or shots	Yes	No	Year___
Fainting spells	Yes	No	Year___	Any other significant			
				defects or illnesses	Yes	No	Year___

Parent's comments on anything checked "yes" above, as well as any comments regarding behavior and any physical problems or injuries:

_____
_____
_____
_____

==========

I hereby give permission for my child to receive emergency medical care, and information on this document may be made available to school and health department authorities.

_____ _____
Signature of parent or legal guardian Date