

# 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, joint diseases	Yes	No	Year__	Mumps	Yes	No	Year__
Skin disorders	Yes	No	Year__	Rheumatic fever	Yes	No	Year__
Eye glasses	Yes	No	Year__	Scarlet fever	Yes	No	Year__
Contact lenses	Yes	No	Year__	Chicken pox	Yes	No	Year__
Visual treatments	Yes	No	Year__	Urinary tract infections	Yes	No	Year__
Treatment underway	Yes	No	Year__	Urinary tract disorder	Yes	No	Year__
Hearing treatments	Yes	No	Year__	Allergies: (circle)			
Treatment underway	Yes	No	Year__	Insect stings	Food		
Hernia	Yes	No	Year__	Pollens	Medicines		
Diabetes	Yes	No	Year__	Dust	Other_____		
Seizure disorder	Yes	No	Year__	Currently on long-term 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