

**AURORA PUBLIC SCHOOL**  
**Student Health Information**

Date: \_\_\_\_\_

Student's Name \_\_\_\_\_  
PLEASE PRINT

Student's Birth Date \_\_\_\_\_ Grade \_\_\_\_\_

Please describe any health conditions that might affect school attendance/performance:

\_\_\_\_\_ No health concerns

\_\_\_\_\_ Asthma

\_\_\_\_\_ Medication, Name \_\_\_\_\_  
\_\_\_\_\_ Inhaler \_\_\_\_\_  
\_\_\_\_\_ Nothing used at this time \_\_\_\_\_

\_\_\_\_\_ Allergies

\_\_\_\_\_ Seasonal, Kind of Allergy \_\_\_\_\_  
\_\_\_\_\_ Medication, Name \_\_\_\_\_  
\_\_\_\_\_ Food, Which ones \_\_\_\_\_  
\_\_\_\_\_ Other: \_\_\_\_\_

\_\_\_\_\_ Diabetes

\_\_\_\_\_ Insulin dependent \_\_\_\_\_  
\_\_\_\_\_ Dosage & Type \_\_\_\_\_

\_\_\_\_\_ Migraine Headaches

\_\_\_\_\_ Medication, Name \_\_\_\_\_

\_\_\_\_\_ History of Seizures

\_\_\_\_\_ Medication, Name \_\_\_\_\_

\_\_\_\_\_ Vision Concerns

Comments:

\_\_\_\_\_ Hearing Problems/Known Losses

Comments:

\_\_\_\_\_ Other Concerns:

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\_\_\_\_\_ Student HAS permission to take non-aspirin pain reliever as needed.

\_\_\_\_\_ Student DOES NOT have permission to take pain relievers as needed.

\_\_\_\_\_  
Parent or Guardian Signature

\_\_\_\_\_  
Date