Central Lake Elementary School

Health Information

Does your child have any of the conditions listed below? Please add any condition present in your child that is not listed below.

*Allergies_____

*Asthma
*Bee Stings
*Diabetes Mellitus
*Epilepsy
*Other_____

* Heart Condition
* Rheumatic Fever
* Severe Eye Difficulty
* Severe Hearing Difficulty

Does your child require any special treatment in school because of any of the above conditions?
__ Yes ___ No

Parent Signature_____

If you answered yes to any of the conditions listed above, please make a statement describing the difficulty and any recommendations for treatment.

_____

_____

Date_____Parent/Guardian Signature_____

Is your child on medication that needs to be administered during school time by school personnel?

___ Yes ___ No Name of Medication:_____

If you answered yes to the above question, **a medical permission form must be filled out** by the Parent/Guardian and the Physician according to State Law, before any school personnel can be involved in giving medication in school.