

ALPHA SCHOOL
STUDENT HEALTH/MEDICATION INFORMATION
2025-2026 School Year

It is **NECESSARY** for us to know if a student takes medication, even if it is only given at home, or if a student has any serious health problem. **It will be kept confidential.** If they become ill, have an accident or need to be taken to the hospital, it is important for emergency personnel to have this information. Also, if there are medication changes at any time during the year, notify the nurse immediately so we can update the medical information. Please fill this form out in its entirety, please write "n/a" for the sections that do not apply.

HEALTH/MEDICATION INFORMATION

Student Name: _____

Birthdate: _____

Does your child take any medication, prescription or over the counter? Yes: _____ No: _____

If yes, please list the medications dose, time, and reason. (Use the back if more space is needed)

Medication	Dose	Time	Reason

Please circle any health problems.

Diabetes	High blood pressure	History of Seizures	Asthma	Environmental Allergies	Hearing deficit	Vision deficit
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List **ALL** medication allergies: _____

List **ALL** food/environmental allergies: _____

Any other food restrictions/dietary concerns: _____

List any other health problems/conditions we should know about: including ADD, ADHD, Autism, Mental Health Problems, Gastrointestinal Problems, etc. _____

Does your child wear glasses/contacts? Yes ___ No ___
 for Distance? _____ Reading? _____

Student's Physician/Pediatrician: _____ Phone Number: _____

Parent/Guardian name (PRINT): _____

Parent/Guardian Signature: _____

Date: _____