



## BASE49 Health Form

This form will be completed by the legal parent/guardian of the student. This form must be completed per student. This form does **NOT** need to be completed by a Healthcare Professional. 'Confidential information will be shared with school staff on a need to know basis'

Student Name(First Name, Last Name): \_\_\_\_\_ Grade: \_\_\_\_\_ School: \_\_\_\_\_

Date Of Birth(MM/DD/YYYY): \_\_\_\_\_

Does your child have any of the following doctor diagnosed health conditions:  
(**Check All That Apply**)

- |  |  |
|--|--|
| <input type="checkbox"/> ADD/ADHD            | <input type="checkbox"/> Migraine Headaches          |
| <input type="checkbox"/> Autism Spectrum     | <input type="checkbox"/> Hearing Loss                |
| <input type="checkbox"/> Heart Condition     | <input type="checkbox"/> Head Injury (or history of) |
| <input type="checkbox"/> Emotional Condition | <input type="checkbox"/> Seizure Disorder/Epilepsy   |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Food Allergy                |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Other                       |

If you checked any condition above, will you be providing medication?

- ☐ YES I WILL
- ☐ NO I WILL NOT
- ☐ MY STUDENT DOES NOT HAVE ANY DIAGNOSED HEALTH CONDITIONS

If rescue medication Is NOT provided, I understand EMS/911 will be called if an emergency arises.

Does your child have any significant life threatening allergies?(**Check one**)

YES                      NO

**If yes**, please list the specific reaction/symptoms your student has experienced:

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Use the space below to list any medications, specific food allergies, and/or any medical conditions not listed above. If none of that applies, then write N/A.

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Recent Hospitalizations (within the last year): \_\_\_\_\_ Date of Hospitalization: \_\_\_\_\_

**Emergency Care Parent Permission:** In case of serious illness or injury, first aid will be rendered in accordance with local school policies. If ambulance service is necessary, parents must assume financial responsibility. If parent/guardian cannot be reached in the event of such an emergency, please send my student to: \_\_\_\_\_ (hospital) or nearest medical facility.

Parent/guardian signature: \_\_\_\_\_

Form Completed by(Print Name): \_\_\_\_\_

Relationship to Child: \_\_\_\_\_

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