

Franklin Township Community School Corporation



STUDENT'S NAME _____ **GRADE** _____
BIRTHDATE _____
SCHOOL _____

Dear Parents,

It is important for the school to be aware of any special health concerns your child may have that affect him/her while during the school day. Because health needs change, current information should be updated each year. Please fill out the section below and return this form to school.

_____ My child has no health problems or physical limitations that will affect him/her at school.

_____ My child has the following medically-diagnosed health concerns that may affect him/her during the school day: (Please check box/boxes and EXPLAIN below):

- | | |
|-------------------------------------|--|
| _____ Asthma | _____ Eye conditions, <u>not</u> including glasses |
| _____ Allergies (please list below) | _____ Heart conditions |
| _____ Bee sting requiring meds | _____ High blood pressure |
| _____ Cancer | _____ Kidney problems |
| _____ Diabetes | _____ Seizure/Epilepsy |
| _____ Hearing problems | _____ Other (explain) |

PLEASE LIST ANY ALLERGIES TO FOOD OR MEDICINE, OR EXPLAIN ABOVE:

Health information is considered confidential. The school nurse cannot share this information with the faculty & staff at your child's school unless there is signed parent permission on file. If it is medically necessary for the above medical information to be shared with the faculty/staff please sign below and contact the school nurse at your child's school.

_____ Date _____ Parent/Guardian Signature and Telephone Number

Thank you,

Faith Muston RN

803-5573

Margie Townsend RN

803-5416

Peg Stanish RN

803-5011

Kerra Waters RN

803-8161

FTCSC Nurses

