Bonner School Health Record

TODAY'S DATE _____

NAME _____ MALE FEMALE DOB_____
last *first* *middle* *circle one*

PHYSICIAN _____ DENTIST _____

PLEASE FILL IN ANY INFORMATION THAT IS APPLICABLE. PLEASE USE THE BACKSIDE FOR ADDITIONAL INFORMATION.

- **Asthma** medications _____ triggers_____
- **Allergy** Specify _____ symptoms _____
- **Diabetes** management_____ doctor_____ onset _____
- **Seizures** medications_____ symptoms_____ onset _____
- **ADD/ADHD** medications_____
- **Visual problems** _____ glasses/contacts _____
- **Hearing problems** _____ frequent ear infections_____
- **Heart condition** _____ specify restrictions _____
- **Congenital/Chronic conditions** _____
- **Serious injuries** _____
- **Operations** _____

Other:_____

_____

Special seating, bathroom privileges, restrictions: _____

_____

Please list medications your student takes both at home and school. **MEDICATIONS TAKEN AT SCHOOL MUST BE CHECKED INTO THE OFFICE.**_____

_____

MONTANA LAW REQUIRES AN UP TO DATE IMMUNIZATION RECORD BE PROVIDED TO THE SCHOOL PRIOR TO ATTENDING. PLEASE PROVIDE RECORD AT TIME OF REGISTRATION. BONNER SCHOOL FAX: 406-258-6153

_____ _____ _____
Individual Completing Form *Relationship to Student* *contact info*

_____

FOR USE BY SCHOOL PERSONNEL ONLY

V I S I O N

YEAR/GRADE						
GLASSES?						
RIGHT EYE						
LEFT EYE						
BOTH						
COLOR						

ADDITIONAL INFO:

DATE:	NURSE/TEACHER COMMENTS