TRINITY HIGH SCHOOL
STUDENT HEALTH INFORMATION FORM
(revised January 2012)

The following information will help the school nurse and staff better understand your son's medical needs. All requested information is essential to have on record in case of an emergency.

STUDENT'S NAME _____ GRADE _____

PARENT /GUARDIAN
Mother _____
Home Phone _____ Work Phone _____ Cell _____

Father _____
Home Phone _____ Work Phone _____ Cell _____

Please submit a current copy of the Commonwealth of Kentucky Immunization Certificate with this form.

Check if any of the following exist:
Allergies
_____ Bee sting, treatment _____
_____ Latex, treatment _____
_____ Peanuts, treatment _____
_____ Respiratory, treatment _____
_____ Other _____

Check if any of the following exist: <u>please provide details on the back of this form</u>
_____ Diabetes
_____ Diagnosed learning disability
_____ Migraine headaches
_____ Hearing problems
_____ Heart condition
_____ Major surgeries
_____ Mobility problems
_____ Vision problems
_____ Seizures
_____ Stomach problems
_____ Other

Medications:
Please list any daily medications (prescription or over the counter) your son takes: *(Include dosage and times he takes the medication.)*
_____
_____
_____

- **If any medication is prescribed to be administered during school hours contact the school nurse.**
- **All prescription and over the counter medications must be brought in the original container to the Student Affairs Office and signed in by the school nurse.**

PARENT SIGNATURE _____ DATE _____