POMONA UNIFIED SCHOOL DISTRICT

800 S Garey Avenue, P.O. Box 2900, Pomona, California 91766 Phone: (909) 397-4648, ext. 28352

HEALTH INFORMATION

Current Year _____ to _____

Student's Name_____

School_____ Grade_____ Birthday_____

Health conditions change. Please fill in current information that the school should know.

1. Does your child take any medications regularly? Yes_____ No_____
   If yes, name medication/dosage/frequency:_____
   _____
2. Is your child
   a. Allergic to bee stings? Don't know_____ Yes_____ No_____
      If Yes, state treatment required_____
   b. Allergic to grass/pollens requiring medication/treatment? Yes_____ No_____
      If Yes, state treatment required_____
   c. Allergic to medicine? Yes_____ No_____
      If Yes, name the medicine_____
   d. Allergic to any foods? Yes_____ No_____
      If Yes, name the food_____
   e. State any other allergy_____
3. Does your child wear glasses/contacts? Yes_____ No_____
   Are glasses for distance?_____ reading?_____ all the time?_____
4. Does your child have a hearing problem? Yes_____ No_____
   Right Ear?_____ Left Ear?_____ Both Ears?_____
5. Does your child have asthma? Yes_____ No_____
   If Yes, do they use an inhaler? Yes_____ No_____
   State the name of the inhaler_____
   How frequently is the inhaler used? More than once a week?_____ 2 – 3 times a month?_____
   1- 6 times a year?_____ Other_____
6. Name any other health condition that the school should be aware of. _____
   _____
7. Is any of this health information new in the last 12 months? Yes_____ No_____
8. What health insurance does your child have? Health Net____ Medi-Cal____ Blue Cross___
   Other_____ None_____

This information is kept in the health office as part of the student's health record. I give permission for the nurse to share this information with school staff if necessary.

_____ _____

Parent's / Guardian's Signature Date