



**NURSING SERVICES**  
 1002 Hastings St.  
 Delta, Co. 81416  
 970-874-7607 Fax 970-874-9505

**STUDENT NAME:** \_\_\_\_\_ **Birthdate:** \_\_\_\_\_ **Grade:** \_\_\_\_\_  
**SCHOOL YEAR :** \_\_\_\_\_ **School:** \_\_\_\_\_

HEALTH CONCERNS	YES	NO	MEDICATION AT SCHOOL (NAME & DOSAGE)	COMMENTS
Asthma				
Severe Allergies (Specify) <input type="checkbox"/> Food _____ <input type="checkbox"/> Latex _____ <input type="checkbox"/> Insects _____				
Diabetes				
Seizures				
Head Injury				
Heart/Blood				
Muscles/Bones/Joints/Skin				
Bladder/Kidney				
Stomach/Intestines/Bowels				
Immune Problems				
Hearing Concerns				
Vision Concerns			Glasses/Contacts <input type="checkbox"/> Yes <input type="checkbox"/> No	
Growth/Nutritional Concerns				
Developmental Concerns				
<input type="checkbox"/> Emotional <input type="checkbox"/> Behavioral <input type="checkbox"/> Bullying Concerns				
ADD/ADHD				
Other Health Concerns				

I acknowledge that I have received and understand the Nursing and Health Services parent letter.  Yes  No

**Activity Restrictions:** \_\_\_\_\_

**Special Equipment required:** \_\_\_\_\_

**Illnesses, Hospitalizations, Accidents/Injuries and dates (use other side if needed):** \_\_\_\_\_

**Healthcare Provider Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**PERMISSION FOR NEED TO KNOW**

I give permission to contact the student's health care provider(s) listed above if needed, regarding the health concerns listed. By signing I agree to the above terms, which shall be continuously in effect for the school year unless terminated by written notice from myself to the school in which my student is enrolled.

**Parent/Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Print Name** \_\_\_\_\_ **Relationship to Student** \_\_\_\_\_