Spring Valley School District
Health Services
Confidential Health Concerns

Date _____
Name _____
Grade _____ Teacher _____

Dear Parent:

For the safety and well being of your child, it is important that the appropriate staff be aware of any health concerns your child may have.

By signing this form you are authorizing the nurse to share this important information with relevant school staff.

Medication Allergy:

Food Allergy: Does your child require placement at the "Nut Free Table"? (Please circle): YES NO

Other Allergy: (i.e. insect bites, bee stings, etc.)

Medication: *If your child requires medication {i.e. Epi-Pen} for Life Threatening Allergies, for the safety of your child, immediately contact your school nurse for further directions

Medical Concerns:

Treatment:

Your prompt return, of this vital form, is greatly appreciated.

_____
*Parent Signature

School Nurse
Health Services