EARLY COLLEGE OF ARVADA
Health Information Sheet

STUDENT'S NAME: _____ SCHOOL: _____DATE: _____

BIRTHDATE: _____TEACHER: _____GRADE: _____

HEALTH INFORMATION

1. Medical doctor's name: _____ Phone Number: _____
   Facility Name: _____
   Results of Last Examination: _____ Date: _____
2. Circle any of these that your child has and describe:
   - Does your student have an Epi Pen? [ ] Yes [ ] No

   Physical Impairments: _____
   Broken Bones, Head or Other Injuries (dates):
   _____
   Operations or Hospitalizations (dates):
   _____
   Other: _____

Healthy Child
No Concerns

[ ]

3. Nutrition or Appetite Concerns (describe): _____
4. Sleeping Habits: Time to Bed: _____ Time Up In Morning: _____
   Difficulties (describe): _____
5. Limitations on Activities Due to Health or Physical Reasons? [] Yes [] No
   Describe: _____

Signature: _____