

# HIH Health in the Classroom

## Student Medical & Allergy Worksheet/Family Preferences

Student's Name: \_\_\_\_\_ Classroom: \_\_\_\_\_

### Medical Conditions

Does your child have any medical conditions that may affect their classroom experience? **Yes** **No**

If **yes**, please describe—

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### Allergies/Sensitivities

Does your child have any allergies or sensitivities? **Yes** **No**

If **yes**, please list the triggers:

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List concerns about skin contact with allergens: (i.e. cannot touch gluten)

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Should your child avoid triggers at all times? If no, clarify. (i.e. no—gluten is ok for snacks at school)

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Does your child require any **medication** for their allergies? **Yes** **No**

If **yes**, please visit the office to obtain the forms to keep otc/prescription & emergency medication at HIH. The school health consultant will connect with you via email.

Preferred email address: \_\_\_\_\_

### Family Dietary Preferences

Does your family/child follow a special diet? (i.e. vegetarian or gluten-free) **Yes** **No**

If **yes**, please describe—

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Do you want your child to adhere to this preference for snacks and lunches?

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**SIGNATURE:** By signing this form, you are consenting to let Hand in Hand discreetly post information about your child's food allergies/sensitivities/family preferences in the cafeteria and classroom as a reminder to all those who interact with your child throughout the day. Medical conditions will disclosed discreetly on a need-to-know basis.

\_\_\_\_\_  
(signature of parent/guardian)

\_\_\_\_\_  
(date)