

# Annual Student Health History Update

Student's Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Grade \_\_\_\_\_ Teacher \_\_\_\_\_

Parent's Name \_\_\_\_\_ Telephone (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_

Address \_\_\_\_\_ Student's Doctor: \_\_\_\_\_

Email address \_\_\_\_\_

Emergency Contact (other than parent): \_\_\_\_\_ Phone: \_\_\_\_\_

PLEASE CHECK "YES" OR "NO" AND IF "YES", EXPLAIN:

**Bus#** \_\_\_\_\_

**Latchkey Y/N** \_\_\_\_\_

CONDITION:	YES	NO	EXPLANATION:
ALLERGIES: <input type="checkbox"/> BEES <input type="checkbox"/> FOOD <input type="checkbox"/> MEDICATION _____	↙	↘	NAME ALLERGY _____ BEE KIT(Epipen): YES NO      BENADRYL: YES NO
ASTHMA			Inhaler at school YES NO
DIABETES <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2			Insulin Pump: YES NO
EPILEPSY/SEIZURES			Medication at home: YES NO If yes, name: Medication at school: YES NO If yes, name:
HEART DISEASE			Explain:
PHYSICAL DISABILITY			Limitations:
SPECIFY ANY OTHER HEALTH PROBLEMS _____ _____ _____			Medication at home YES NO If yes, name: Medication at school YES NO If yes, name:  Any other concerns: _____

**\*\*Parent must supply school with any medicines the child needs. PARENT MUST BRING MEDICINE TO SCHOOL IN ITS ORIGINAL CONTAINER.** Written permission and instructions for giving medicine must be on file at the school. Forms are available at school.

*Your signature confirms the above information is accurate and can be used by the school system and the school nurse to update your child's health record. It also gives the school nurse permission to perform MINIMAL screening (example-temperature, ice, band-aids, etc) on your child in the event of illness or injury at school.*