**ANNUAL HEALTH INFORMATION UPDATE**

*This information is kept confidential and used only by the nurse to make medical decisions in the child’s best interest. Disclosure of this information is optional.*

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Student’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_

Student’s Date of Birth: \_\_\_\_\_\_\_\_\_\_\_Teacher/Grade: \_\_\_\_\_ Insurance: Medicaid Other None

Physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_ Dentist:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_

**Please complete the following, regarding health concerns that pertain to the student named above:**

Takes medication? \_\_\_\_at home / \_\_\_\_at school / \_\_\_\_daily / \_\_\_\_as needed / \_\_\_\_Emergency only

Name of medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dosage: \_\_\_\_\_\_\_\_\_\_ Time(s): \_\_\_\_\_\_\_\_\_ Reason for medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dosage: \_\_\_\_\_\_\_\_\_\_ Time(s): \_\_\_\_\_\_\_\_\_ Reason for medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Eyes:** \_\_\_\_glasses / \_\_\_\_contacts / \_\_\_\_reading / \_\_\_\_distance / \_\_\_\_lazy eye / \_\_\_\_difficulty seeing

**Ears** (circle)**:** R Lfrequent infections / R L tubes / R L hearing difficulty / R L hearing aid—wear at school? Y N

**Does your child have** (check all that apply)**:**

**Allergies:** \_\_\_\_No / \_\_\_\_Yes to: \_\_\_\_drugs / \_\_\_\_food / \_\_\_\_pollen / \_\_\_\_bee sting

Please list:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has the allergy required emergency action in the past? Y N Comments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Asthma:** \_\_\_\_No / \_\_\_\_Yes Triggered by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Treatments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Diabetes:** \_\_\_\_No / \_\_\_\_Yes Takes insulin? \_\_\_\_No / \_\_\_\_Yes Date diagnosed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Epilepsy/Seizures:** \_\_\_\_No / \_\_\_\_Yes Describe seizure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_

**Heart Condition:** \_\_\_\_No / \_\_\_\_Yes Describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physical Restrictions?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Bone or Joint problem:** \_\_\_\_No / \_\_\_\_Yes Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physical Restrictions?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Other Concerns** (check all that apply)**:**

\_\_\_\_nosebleeds / \_\_\_\_eating / \_\_\_\_sleeping / \_\_\_\_bowel / \_\_\_\_skin / \_\_\_\_bladder / \_\_\_\_bedwetting / \_\_\_\_dental

\_\_\_\_blood disorder / \_\_\_\_neurologic / \_\_\_\_lungs / \_\_\_\_headaches / \_\_\_\_menstruation / \_\_\_\_blood pressure

\_\_\_\_phobias (fears) / \_\_\_\_ADD/ADHD

**List:** Surgeries, injuries and serious illness:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Best way to reach parent during the day: \_\_Home / \_\_Work / \_\_Cell / \_\_Text**

Who should we call first (circle): Mom Dad Both Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mom Work #: \_\_\_\_\_\_\_\_\_\_\_ Cell#: \_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dad Work #: \_\_\_\_\_\_\_\_\_\_\_\_ Cell#: \_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home: \_\_\_\_\_\_\_\_\_Work:\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_

**If student requires medication at school or a change in PE participation, please obtain the appropriate form in the nurse’s office.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Legal Guardian Signature Date

**\*\*NOTICE\*\* The Nurse’s Office in this district is equipped with pre-filled epinephrine auto syringes and asthma-related rescue medications that can be administered by the school nurse or other trained personnel in the event of life-threatening emergencies involving anaphylaxis or asthma.**