Annual Student Health History Update/ ___________________ SCHOOL (2016-17)

Student's Full Name: ______________________ **Date of Birth:** ________ **Grade:** _____ **Teacher:** ____________

Parent's Name: ______________________ **Phone Numbers:** ______________________

Address: ______________________ **Student's Doctor:** ______________ **Phone #:** ____________

Email Address: ______________________ **Emergency Contact:** ______________ **Phone #:** ____________

Bus Rider: ____#_______ **Car Rider:** ___ **Driver:** ____ **After- School Program:** ______ **Latchkey:** ___________

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 medications must be on file at the school. Forms are available in the school office. ***Your signature confirms the information below 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 or designated staff permission to perform MINIMAL screening (temperature, etc) and first aid (using ice, antibiotic ointment, hydrocortisone, Chloraseptic throat spray, bandages, etc. as needed) on your child in the event of illness or injury at school.*** **Emergency Action Plans will only be written for students who have all appropriate forms, documentation, and medications at school.**

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Parent and /or Guardian Signature **Date**

☐ **My Child does not have any medical conditions at this time** (*DO NOT MARK ANY OTHER BOX*)

☐ **My Child has the following conditions checked (√) below**

☐ ***LIFE THREATENING ALLERGIES THAT REQUIRE EMERGENCY MEDICATION AT SCHOOL***

BEES: ______________________

Medication for LIFE THREATENING ALLERGIES

FOOD: ______________________

MEDICATION: ________________

OTHER: ______________________

Epinephrine Auto-injector: __________ **Type:** ______

Benadryl: ____________

☐ ***ASTHMA THAT REQUIRES INHALER AT SCHOOL*** **TYPE OF INHALER:** ______________________

☐ ***DIABETES*** **Does your child use an Insulin Pump?**

TYPE 1: ______________

TYPE 2: ______________

Is your child on any other medication for DIABETES?

(Please attach list of medications/ diabetic orders from Physician)

☐ ***EPILEPSY/SEIZURES NOT RELATED TO FEVER***

Is your child on medication for SEIZURES?

At home? ________ **At school?** __________

☐ ***HEART DISEASE*** **What condition does your child have?**

☐ ***PHYSICAL DISABLITY*** **Please describe any physical disabilities & limitations**

☐ ***OTHER HEALTH PROBLEMS including history of Medically diagnosed Concussion***

Attach any medical documentation to this sheet. ***Medical documentation must be updated every year.***

☐ ***LIST OF MEDICATIONS taken at home that may affect student at school:*** *Use back of sheet if needed.*

School Nurse Use Only: ______________________

Communication: ______________________

EAP written/Distributed to staff: ______________________

form revised 4/27/16ssc