

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:

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