SCHOOL HEALTH UPDATE

Student Name: _____ Date of Birth: _____ Grade: _____

Dear Parent/Guardian:

Each year we need to update our health records as children's health conditions change. Please answer each question and return to the school nurse so that your child's health record will be up to date. If any changes occur later in the year, please notify the school nurse.

1. Has student had the chicken pox disease? No ___ Yes ___ If yes, age or date _____
2. Does your child have any **medically** diagnosed condition? No ___ Yes ___
   If yes, please list:

   Diagnosis: _____

   Date of diagnosis: _____

   Doctor that diagnosed: _____

   Date the problem last occurred _____

3. Does your child take medication? No ___ Yes ___

   If yes, please list medication(s) _____

4. Does your child have any **medically** diagnosed food/medication allergies? No ___ Yes ___

   If yes, please list: _____

   Type of reaction: _____

   Date of diagnosis: _____

   Doctor that diagnosed: _____

   Date the problem last occurred _____

   a. Does your child require medication in the event of an allergic reaction? No ___ Yes ___
      If yes, **a doctor's order is required**. Contact the school nurse for the appropriate form. **The school does not provide EpiPens**

5. Does your child have a **medically** prescribed need to take medication during school hours?
   No ___ Yes ___
   a. If yes, a written parental consent and physician instructions are both needed and must be renewed each year. Contact the school for the appropriate medication administration form.
   b. As part of our Shelter in Place Program, we need to consider the possibility that students may need to stay in school for 72 hours. Please discuss with your doctor the need to leave essential medications in school for an emergency. If medications will be needed, please contact school nurse for appropriate administration form.
6. Are there any medically documented physical restrictions concerning your child?
   No ___ Yes ___
   a. If yes, what are the limitations? **A doctor's note is required.** _____
   _____
7. Date of last dental visit: _____
8. Doctor, clinic, health or medical center that cares for student:

   Name: _____

   Address: _____

   _____

   Phone Number: _____

By signing this document, you are giving permission for the Health Room staff to share this information with school staff for the well-being of your child.

Signature of Parent/Guardian: _____

Date: _____