STUDENT HEALTH INFORMATION
2017-18 ANNUAL UPDATE

Student Name________________________________ Grade__________________

Dental Exam_____/_____ (month/year) **Vision Exam(by Eye Dr.)_____/_____** (month/year)

Please complete a form for **each** child enrolled in school. If your child does not have any special health needs, please complete this form by marking "My child has no special health needs" and return it to school.

_________ My child has no special health needs

Please indicate if any of the following conditions are relevant for your child. Provide additional information for the following conditions on the space provided below.

___________**ALLERGIES:**

1. To what? ____
2. Is Epipen prescribed for this allergy? Yes___________ No____________
3. How does your child react to this allergy? ______________________________

___________Due to allergies/medical condition: Are special meals needed? ____________"Nut-Free" lunch table?___________ ******* If Yes—contact the hot lunch coordinator**

___________ **Asthma**-Is an Inhaler or Nebulizer prescribed? _____ Yes _____ No. Use before P.E. Class?__________________ Use before recess?_______________________

_______ **ADD/ADHD**

_______ **Diabetes**-Type______________________________________

_______ **Hearing loss**-Need preferential classroom seating? _______ Wear a hearing aid?_______

_______ **Heart Problems**- Specify diagnosis:_________________Restrictions?__________________

_______ **Medications:**_________________(**Any** medication to be administered by school staff requires written physician authorization, **this includes over the counter medicines**).

_______ **Seizures**-Type:_________dates:______________Restrictions?__________________________

_______ **Vision**-Does your child wear glasses? ______Contact lenses?______Color blind?_______

_______ **Concussion**-Date_________Restrictions?____

________**Other**:_____________________________Restrictions?_________________________________

******Action plans (signed by a physician & parent) are requested for the following health conditions: Asthma, Diabetes, Seizures & Severe Allergies.**

Limited medical information (diagnosis, medication) will be shared with pertinent school staff to facilitate a safe learning environment UNLESS parent/guardian submits a written waiver.

Parent/Guardian Signature: ____Date: _____________

ANY MEDICATION TO BE ADMINISTERED BY SCHOOL STAFF REQUIRES WRITTEN PHYSICIAN AUTHORIZATION—THIS INCLUDES OVER THE COUNTER MEDICINES