SCHOOL NO. 2 HEALTH OFFICE

2021-2022

YEARLY STUDENT HEALTH UPDATE FORM

Please fill out and return

Please PRINT CLEARLY

STUDENT’S NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GRADE:\_\_\_\_\_ BIRTHDATE:\_\_\_\_\_\_\_\_\_

In order to update your child’s health file, please supply the following information:

1. List ALL allergies, including foods:
2. List any chronic conditions, such as asthma, heart murmurs, etc.
3. List any medications your child is taking (\*Note: Please contact the nurse if medication needs to be given in school)
4. Does your child wear glasses/contact lenses? Yes\_\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_
5. List any speech, hearing or physical impairment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. List any injuries, surgery, diseases, hospitalizations, or immunizations your child has had since June, including dates: (\*Note: immunizations must be confirmed by the physician in writing)

As parent/guardian of the above named student, I hereby authorize the release of pertinent medical information (medical conditions, allergies, and/or medication regimes) to be exchanged among appropriate professional staff involved in the care of the above student. I am also aware that my child will have the following health screenings: vision, hearing, height, weight, blood pressure, and, if age ten or more, scoliosis. This consent is valid for the 2018-2019 school year and is intended to allow staff to better serve my child.

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

 Name of Parent/Guardian Signature of Parent/Guardian Date