2016—2017 HEALTH UPDATE INFORMATION

Student Name	Birthdate	Grade	Does your child wear…. Glasses Contacts None	Family Medical Doctor

Does your child have any health problems? **Check all that apply below** Use back of form if needed

_____ ADHD _____ DEPRESSION _____ HEART PROBLEMS _____ DIABETES _____ HEARING LOSS _____ CEREBRAL PALSY

_____ MENTAL DISORDER _____ SEASONAL ALLERGY _____ LATEX ALLERGY—Reaction Type (respiratory or rash)

_____ Asthma—**Will an inhaler need to be kept in the office at school? YES or NO**

_____ Allergy **(Severe)** food or nut (List) _____ **Will EPI-Pen be brought to school? YES OR NO**

_____ Food Allergy: (Doctor's note is required for special meal/food replacement) (LIST) _____

OTHER—Conditions/Concerns: (Use back of form if needed) _____

_____

List any immunization or boosters received in the last year. (DO NOT INCLUDE KINDERGARTEN/PRE-K SHOTS)

(Include type, date, given by)

Mediations Taken by student at home or at school on a daily basis—Use back of form if more space is required

Medication	Dosage	Taken at (time)	Given at HOME School Both
Medication	Dosage	Taken at (time)	Given at HOME School Both
Medication	Dosage	Taken at (time)	Given at HOME School Both

The information given above is confidential.

I give permission to share this information with school staff working with the student. All student forms are kept in the Nurse's office at the Middle School building.

PERMISSION FOR Acetaminophen 325 mg **Please circle one: YES or NO** *Does not cover any other medications*

(Generic Tylenol)

Signature _____ ***(Circle Yes or No above)*** Date _____ Relationship to Student _____