

Annual Health Report 2015/2016

Dear Parents/Guardians,

In order for us to keep your child's health record up to date, we would like you to provide the following information:

Child's Name _____ Date of Birth: _____ Grade _____

Date of most recent visit to:

Family doctor: ___/___/___ Name of doctor: _____ Phone #: _____

Eye doctor: ___/___/___ Name of eye doctor: _____ New glasses or contacts? _____

Dentist: ___/___/___ Name of dentist: _____

Immunization/booster in the last year? Yes ___ No ___ (If yes, please send copy of date with doctor's signature/stamp)

Accidents/illnesses/surgeries within past year: _____

Please list any medication your child takes regularly: _____.

If it is medically necessary for your child to have medication administered at school, please contact the school nurse so a medication permit can be sent home for the parent and doctor signature. Do not send medications in to school with the student.

Please check the following conditions that currently apply to the student. Include a brief explanation and any dates where appropriate in the space below. Please notify your school nurse with any concerns/questions. Thank you.

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| _____ ADD/ADHD (circle one) | _____ Fainting |
| _____ Allergic to bee stings
mild ___ moderate ___ severe ___ (check one) | _____ Head injury/concussions |
| _____ Allergic to food (list below)
mild ___ moderate ___ severe ___ | _____ Heart disease/defect |
| _____ Allergic to medication or other (list below) | _____ Kidney disorder |
| _____ Asthma | _____ Menstrual cramps (severe) |
| _____ Birth defect/chromosome disorder | _____ Mental health issues |
| _____ Cancer/leukemia/blood disorder | _____ Migraine headaches |
| _____ Cerebral palsy | _____ Nosebleeds (frequent) |
| _____ Color blind | _____ Physical activity limitations (list below) |
| _____ Cystic fibrosis | _____ Scoliosis |
| _____ Diabetes | _____ Seizures |
| | _____ Other (list below) |
| | _____ No known health problems |

Explain: _____

If your child requires accommodations at school due to a medical condition, please provide documentation of the medical condition from your child's doctor to the school nurse.

It may be necessary to share health information with your child's teacher (either verbally, in written form, or by e-mail) to ensure their safety and welfare. Please give your consent to the sharing of pertinent health information by signing below.

Parent/Guardian Signature _____ Today's date _____

Thank you for your help and let's have a healthy school year!

Barbara Carter RN, School Nurse