

Visiting Nurse Health Services  
School Health Program

Annual Student Health Update  
2011 - 2012

Name \_\_\_\_\_ School CTK Grade \_\_\_\_\_

1. Your help is needed to update your child's health status and assist school personnel to identify potential classroom emergencies and health issues, which may affect your child's learning. Please complete this form and return to school by \_\_\_\_\_.

Check any health concerns below, which pertain to your child:

_____ ADD/ADHD	_____ Allergies, specify	_____ Asthma	_____ Hearing
_____ Diabetes	_____ Heart problems	_____ Injuries	_____ Recent surgery
_____ Mental/emotional	_____ Seizures	_____ Scoliosis	_____ Vision
_____ Other, specify _____			

If you checked any of the above, please specify symptoms, treatment, restrictions and needed adjustments. \_\_\_\_\_

\_\_\_\_\_ My child has no health needs requiring special consideration at school.

*IT IS THE PARENT'S RESPONSIBILITY TO NOTIFY THE SCHOOL NURSE IF CHANGES OCCUR.*

2. List all medications (include inhalers) your child is currently taking (include name, dose, time, and reason): \_\_\_\_\_

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

*THE MEDICATION AUTHORIZATION MUST BE COMPLETED FOR MEDICATIONS GIVEN AT SCHOOL.*

3. List immunizations received in the **PAST YEAR ONLY** (month/day/year) so your child's student health record may be updated: \_\_\_\_\_

\_\_\_\_\_

4. History of Chicken Pox Disease? \_\_\_\_\_ Yes, specify year \_\_\_\_\_, \_\_\_\_\_ No

5. Date of last exam by eye care provider and results \_\_\_\_\_

6. Date of last exam by dentist and results \_\_\_\_\_

7. List physician/phone numbers, include specialists: \_\_\_\_\_

\_\_\_\_\_

I understand the above information may be shared with school personnel responsible for the well being of my child.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Phone Number (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cellular) \_\_\_\_\_