2010-2011 Annual Health Status Update

School: _____ Student Name: _____

Teacher: _____ Grade: _____ DOB:_____

Dear Parent:
In order to plan for your child's health care needs during school hours we need current and relevant health information. This information will be shared with appropriate school staff. *If a current health concern is identified, a plan of care will be sent home for additional information.*

PLEASE COMPLETE AND RETURN THIS FORM TO THE SCHOOL NURSE

1. Does your child have any severe allergy that requires emergency medical treatment? __Yes __No
Type allergy: Food_____Insect_____Drug_____
Other : _____ If so, has an emergency injection been prescribed? ____Yes ____No

2. Does your child have asthma as diagnosed by a doctor? ___Yes ___No
Doctor's name: _____ Phone: _____

3. Is your child currently under a doctor's care for any of the following?
Please check all that apply.
_____ Special dietary needs: (please explain) _____
_____ Attention Deficit Disorder
_____Attention Deficit Hyperactivity Disorder
_____Convulsions/Seizures, approximate date of last seizure _____
_____Diabetes
_____Other – Describe any other health concern or illness your child has: _____

4.		
Has your child ever had surgery or an operation?	Y N	If Yes, please explain:
Has your child had any serious injuries, or accidents?	Y N	If Yes, please explain:
Does your child currently need or take prescription medications?	Y N	If Yes, please explain:
Does your child take vitamins, herbal preparations or over the counter medications?	Y N	If Yes, please explain:
Does your child have any physical limitations that may prevent or limit his or her participation in physical education?	Y N	If Yes, please explain:
Has your child seen a dentist in the last year?	Y N	If Yes, Who?
Do you have any concerns about how your child is eating or your child's weight?	Y N	If yes, explain:

5. Please circle if your child has now or has ever had any of these problems:

Lots of headaches	Vision problems Eyes crossing	Head Injury	Hearing problems	Lots of ear infections	Lots of runny noses	Lots of sore throats
Passing out or Fainting	Gum or nose bleeding	Other bleeding problems	Heart problems or heart murmur	Chest pain or chest tightness	Cough at night or with exercise	Wheezing or noisy breathing
Shortness of breath	Tooth or dental problems	Lots or stomach pain or problems	Throwing up or vomiting	Diarrhea	Hard poop or constipation	Bladder, urine or kidney problems
Anxiety	Difficult Periods	Mental Health	Difficult Behavior	Learning Problems	Acne	Substance Abuse
Numbness and tingling	Back pain	Leg or arm pain	Difficulty walking or running	Easy bruising	Anemia	Tuberculosis (TB)
Rashes or skin problems	Problems being too hot or too cold	Sleeping or bedtime problems	**Explanation of circled items/use back of form as needed:**			

6. Has your child received special services in school? (speech, PT, Focus, etc.) _____

7. Was your child born in this country? Y N If No, how long has your child been in the US? _____
If No, which country was your child born in? _____ Which language does you family prefer to speak? _____

8. My child's last doctor visit was _____ with _____

Parent/Guardian Signature: _____ Date: _____

Phone number: _____ (Home) _____(Work) JBR 08/06