HARDING TOWNSHIP SCHOOL

ANNUAL HEALTH UPDATE

Student's Name: ______________________________ DOB: ________________ Age: ___________ Grade________

Have there been any changes to your child's health over the summer (accidents, illnesses, surgeries, etc.)? YES NO

If yes, explain: ____

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HEALTH CONDITION	YES	NO	If, YES PLEASE EXPLAIN
Severe Allergies			Circle those that apply: Medication Food Bees/Insects Other Specify:____ Is an Epi Pen required? YES NO
Asthma			Medication needed: YES NO Will an inhaler be needed in school? YES NO
Seizures Type:			Last Seizure: Medication: Is medication needed at school? YES NO
Heart Conditions			Type: Treatment:
Migraines/Frequent Headaches			Triggers: Treatment:
ADD/ADHD			Medication:
Vision Problems			Specify: Are Glasses/Contacts Worn? YES NO If yes, when? Distance Reading
Hearing Loss/Ear Infections			Specify: Hearing Aides: YES NO
Head Injury/Concussion			When:
Gastrointestinal			Describe:
Skin			Describe:
Musculoskeletal			Describe:
Other: (use back for additional information)			

MEDICATIONS: Please list any medications that your child takes on a daily basis (name, dose, frequency)

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Please list any other information about your child that you would like the school nurse to be aware of: _______________

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Parent Signature: ____ Date: ______________________________

Please note that this is confidential health information that will only be shared with school staff that need to know to protect the safety of your child. Staff is aware that the information shared with them is confidential. If you do not want information share please notify the school nurse.

PLEASE RETURN TO THE SCHOOL NURSE