

Annual Health Report
2022-23

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 _____

For Parents of High School Students Only:

Do you wish your child to be given any of the following per request from a stock bottle in the nurse's office?

Acetaminophen (Tylenol) Yes No Ibuprofen (Advil) Yes No

Date of most recent visit to:

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

Immunization/booster in the last year? Yes ___ No ___ (If yes, please list type and date)

Type: _____ Date: _____

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

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.

Please check the following conditions that apply to the student (if they are changes). 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 | _____ 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 (list below) | _____ Kidney disorder |
| _____ Allergic to other (list below) | _____ Lice |
| _____ Arthritis | _____ Menstrual cramps(severe) |
| _____ Asthma | _____ Mental health issues |
| _____ Birth defect/Chromosome disorder | _____ Muscular Dystrophy |
| _____ Blood Disorder | _____ Migraine headaches |
| _____ Blood/ Blood Products not given | _____ Nosebleeds (frequent) |
| _____ Cancer/Leukemia | _____ Osgood- Schlatter's Disorder |
| _____ Cerebral Palsy | _____ Physical activity limitations |
| _____ Color blind | _____ Rheumatic Fever History |
| _____ Cystic Fibrosis | _____ Scoliosis |
| _____ Diabetes | _____ Seizures |
| | _____ Other (list below) |
| | _____ No known health problems |

Explain: _____

It may be necessary to share health information with your child's teacher and/or coach (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 (if you have questions or concerns about this, please do not hesitate to call):

Parent/Guardian Signature _____ Today's date _____

PLEASE NOTE: If you think that your child's medical condition necessitates accommodations in school, please send in a doctor's note documenting this diagnosis to the school nurse.