HEALTH SUMMARY
MUST BE RENEWED ANNUALLY

Student Name: _____ **Phone:** _____ **Birth date**: _____ **Grade:** _____

Current Address: _____

Please note: Student health concerns, including, but not limited to: food allergies/bee sting allergies, diabetes, breathing problems, seizures or any health issue that could interfere with your child's learning will be shared with classroom teachers and appropriate staff who "Need To Know" unless you specify otherwise by notifying the school nurse.

Current Physician/Health Care Provider: _____ **Phone** _____
Date of last visit to physician: _____ **Reason:** _____

Has this child had any of the following during the last year? (If yes, please explain in space provided)

- Severe injuries requiring medical attention _____
- Serious illness or operations _____
- Visits to the emergency room for treatment _____
- Changes in wearing glasses or contact lenses _____
- New allergies diagnosed _____
- Chronic disease diagnosed _____
- Asthma or breathing problems _____
- Seizures/Convulsions _____
- COVID-19 _____

Is this child receiving any prescribed medication? (If so, please list)

Has this child received any immunizations since last year? (If so, please list with dates and provider)

Are there any family changes or difficulties, which may influence school performance or behavior?

Are there any other services or agencies involved with your child or family? (e.g. counselors, therapists, social service agencies. If so, please list)

Is there any other information about the health and well being of this child which is important for a successful school experience this year? (If so, please describe)

_____

Completed by:
Print name _____ **Relationship to Student:** _____ **Date:** _____

Signature _____

3/29/23