Bristol Warren Regional School District
Annual Health Record Update

IT IS THE PARENT/GUARDIAN'S RESPONSIBILITY TO NOTIFY THE SCHOOL NURSE OF ANY CHANGES REGARDING YOUR CHILD'S HEALTH.

School Year: _____School: _____ Grade: _____ Teacher: _____

Student's Name: _____

1. **Does your child have any of these health problems?**
   Diabetes___ Asthma___ Heart_____ Seizures_____ ADHD_____ Hearing_____ Vision _____
   Explain _____
2. **Does your child use an inhaler? YES ___ NO___** If yes, specify _____
   _____
3. **Does your child wear glasses/contacts? YES___ NO___** For: Reading___ Distance__ Full time__
4. **Does your child take medication at home? YES___ NO___** ***List medications, dose and frequency.***

_____
_____

5. **Does your child have any allergies to foods, medications or environment? YES___ NO___**

Type	Reaction	Treatment
_____	_____	_____
_____	_____	_____

General Dental Health Screening Requirements Every student shall be given an annual dental screening by a licensed dentist or dental hygienist through the fifth (5th) grade.

6. **Do you wish to have your child participate in the annual dental screening? YES __ NO* __**
   (Students who are screened by private dentists/dental hygienists and who provide written documentation of the screening being performed at the prescribed intervals may elect not to be screened.)

****If you answered NO please provide written documentation from your dental office.***

Dentist: _____ **Last Visit:** _____
*(If this information is not provided, your child will be required to participate in the Dental Screening.**)***

7. **Would you like your child to receive free dental care through the East Bay SMILES Program & MOLAR Express? YES __ NO __ (consent forms to follow.)**

8. **Annual Hearing Screenings will be completed by the RI Hearing Center. Does your child have: History of ear infections? YES __NO __ Does your child have Ear Tubes? YES __ NO __ Are ear tubes still patent? YES __NO __**

9. **Is there anything more about your child's health that you think is important for us to know?**

_____
_____

Health information will be shared with appropriate school staff for the health and safety of your child.

I GIVE THE SCHOOL NURSE PERMISSION TO CONTACT MY STUDENT'S PHYSICIAN, DENTIST OR OTHER AGENCIES SHOULD IT BECOME MEDICALLY NECESSARY.

_____ _____
Parent/Guardian Signature **Date**