

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 _____