

BRADFORD ELEMENTARY SCHOOL

Part of the Oxbow Unified Union School District | A Community of Learners Empowered Through Experience

Student Name: _____ **Birth Date:** _____ **Grade:** _____

Annual Health Update

The purpose of the Annual Health Update Form is to enable parents/caregivers to share important medical information needed by the school to ensure that your child is safe at all times.

It is your responsibility to provide the school with the most up to date immunization record for your child. This is a requirement for school attendance. Thank you!

Is your child's most recent immunization record on file with the school nurse? Yes ____ No ____

Doctor's Name: _____ **Doctor's Phone:** _____

Date of Child's Last Wellness Visit: _____

Dentist Name: _____ **Dentist Phone:** _____

Date of Child's Last Dental Visit: _____

Prescription Medications

Students who are in need of taking prescription medications during the school day are required to bring them to the health office in the original prescription container. A signed physician order as well as signed parental consent are BOTH required before medications will be administered to your child. Proper documents for prescription medications can be obtained from the BES school nurse.

Does your child take daily medications? Yes ____ No ____ If yes, please complete below:

Drug Name	Dose	Given at School or Home	Reason for Use

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Student's Medical History

Question	Yes	No	Explanation
Does your child have allergies? If so, to what?			
Does your child require an EpiPen or Benadryl for an allergy?			
Does your child have any dietary restrictions?			
Has your child ever been told they had asthma?			
Does your child still have asthma?			
Does your child have an inhaler for asthma?			
Does your child have diabetes?			
Does your child have Epilepsy or Seizure Disorder?			
Has your child had surgeries within the last year?			
Has your child ever had a concussion? Please note ages and/or dates.			
Does your child have a heart condition?			
Does your child wear glasses or contacts?			
Does your child have hearing problems?			
Does your child have a mental health condition?			
Does your child have a bleeding disorder?			
Does your child have frequent headaches?			
Does your child have any other health conditions?			

Signature of Parent/Guardian: _____ **Date:** _____