CENTRAL YORK
SCHOOL DISTRICT

STUDENT HEALTH UPDATE

Student Name:_____Date of Birth:_____Grade:_____

CHRONIC health conditions and care needs during the school day:

Cerebral Palsy ___ Cystic Fibrosis ___ Sickle Cell Disease___ Spina Bifida___ Other___

EMERGENCY health conditions and treatments that may be needed at school:

Asthma___ Diabetes___ Heart Condition___ Seizures___ Other___

LIFE-THREATENING ALLERGIES

List the specific allergy, along with the symptoms of your child's most recent reaction and how it was treated.

Foods___ Latex___ Medications___ Stings___ Other___

CURRENT MEDICATIONS: Please include all medications your child is taking.

Medication	Dose	Reason for taking the medication

Please share other health concerns about your child and their possible needs during the school day.

YES/NO ADD/ADHD_____

YES/NO Allergies (non-life-threatening):_____

YES/NO Hearing or Vision Problems:_____

YES/NO Migraines or Fainting:_____

YES/NO Nutrition/Special Dietary Need: _____

YES/NO Other Health Concerns:_____

Please list the best emergency phone numbers to call during the school day (please include name & number):

1.)_____

2.)_____

PERMISSION FOR ANALGESIC AT SCHOOL: Please access Skyward or check the following boxes to give parent consent for over-the counter medications during the school day: __TYLENOL __IBUPROFEN __PEPTO BISMOL __TUMS

I give permission to share information about my child's health with the adults responsible for my child's on-going safety at school. **Parent Signature_____Date:_____**