RICHLAND SCHOOL DISTRICT TWO
ANNUAL HEALTH UPDATE
2025- 2026

PLEASE PRINT CLEARLY

Child's Name *First* *Middle* *Last*			**Date of Birth**	**Grade**
Mother's Name	**Cell phone**	**Emergency Contact Name**	**Cell phone**	
Father's Name	**Cell phone**	**Emergency Contact Name**	**Cell phone**	
Who is your child's regular doctor?		**What type of health insurance coverage does your child have?**		
Does your child have any LIFE-THREATENING ALLERGIES to LATEX, FOOD, MEDICATIONS, INSECTS? ☐ **Yes** ☐ **No** **Please list LIFE-THREATENING ALLERGIES:** _____		**Will you be providing an EpiPen for school?** ☐ **Yes** ☐ **No**		

Note: Food and Nutrition Services require a yearly medical note for special diets, food substitutions, and food avoidance due to allergies. Accommodations and substitutions will only be made with a physician's note.

CURRENT physician-diagnosed health conditions:

Contact your school nurse to discuss your child's individual needs related to their health condition and to obtain medication permission forms, medical orders for tube feedings, catheterization, trach care, etc.

Does your child have asthma? ☐ **Yes** ☐ **No** **When was his/her last problem with asthma?** _____	**Will you be providing an inhaler for school?** ☐ **Yes** ☐ **No**

Condition	**Please check if "Yes"**	**Condition**	**Please check if "Yes"**	**Condition**	**Please check if "Yes"**
Blindness/ Deafness		**Diabetes**		**Neuromuscular Disorder**	
Bleeding Disorder (e.g. Hemophilia)		**Heart Disorder**		**Seizure Disorder**	
Blood Disorder (e.g. Sickle cell)		**High Blood Pressure**		**Other- Please list**	

District Medication Policy: Medication must be in a properly labeled *original* unopened container. This includes prescription and over-the-counter medication. A completed school Medication Permission Form is required for EACH medication. Prescription medications require the parent's signature AND a physician's signature.

Medication will not be given without the above requirements being met. The district reserves the right to refuse to administer medications at school until the parent AND physician have signed the forms.

THIS INFORMATION WILL BE KNOWN ONLY TO THE SCHOOL NURSE AND TO HEALTH ROOM PERSONNEL. FOR YOUR CHILD'S SAFETY, HIS/HER TEACHERS AND OTHER PERTINENT SCHOOL PERSONNEL MAY BE NOTIFIED. IF YOU DISAGREE WITH THIS OR HAVE QUESTIONS, PLEASE LET THE SCHOOL NURSE KNOW.

Parent/Guardian signature _____**Printed Name**: _____**Date** _____

Updated March 2025