San Jose Unified School District

Student Health Update Information

School Year: _____

Dear Parent,
Your answers to the following questions will provide valuable information that will assist SJUSD nurses and staff to plan your child's school program and identify health services needs. After completing the questionnaire return it to your child's school health office. If you have any questions please contact the school nurse at your child's school.

Student Name: DOB:

School: Grade: Teacher:

Parent/Guardian Name:

Parent/Guardian Phone Numbers:

Please circle all that apply to your child:

Food Allergy	Seasonal Allergy	Vision Problems	Diabetes Type 1	Diabetes Type 2	Asthma
Bee Sting Allergy	Severe Allergy Requiring Epipen	Wears Glasses and/or Contacts	History of hearing problems	Wears hearing aids	Seizures

List any other medical/health conditions that your child has:

If you indicated that your child has any health conditions/concerns please explain and/or provide any further information that you would like us to know:

Does your child currently take medication at home? YES NO
If yes, please list here:_____

Does your child need medication at school: YES NO
If yes, please list here:_____

Does your child have a regular health care provider? YES NO
Healthcare Provider Name: Phone:

During the past year , has your child had any serious illness, operation, or accidents? YES NO
If yes, when did this occur?_____Was he/she admitted to the hospital? YES NO
Explain:

Does your child currently have health insurance? YES NO
If yes, please circle the type of insurance:
Medi-Cal Healthy Kids Kaiser Child Health Plan Covered CA Private

If your child does not have health insurance would you like our Healthy Start staff to contact you with more information on health insurance options? YES NO

Parent Signature: Date: