ANNUAL HEALTH INFO UPDATE

(**FRONT AND BACK** TO BE COMPLETED BY **PARENT / GUARDIAN** AND RETURNED AT TIME OF ENROLLMENT)

Student's Name_____Date of Birth_____Grade _____

Please complete the following checklist and give details below (attach any additional pertinent information).

Does the student currently or had in the past year, any of the following conditions?

	YES	NO
Allergies / seasonal, food, environmental (specify allergen & reaction below)		
Bee / Insect Sting Allergy or Reaction		
ADHD / ADD		
Anemia (include Sickle Cell)		
Arthritis		
Asthma (give details below)		
Back / Neck Injury		
Bladder / Kidney Disease		
Bleeding / Clotting Disorder		
Cancer / Leukemia		
Chickenpox		
Convulsion/ Seizures		
Diabetes		
Head Injury / Concussion		
Headaches		

	YES	NO
Hearing Loss / Correction		
Heart Condition / Murmur		
Hepatitis		
Hernia		
Lead		
Lung Disease / Tuberculosis		
Measles		
Medication Reaction / Allergy (list below)		
Mononucleosis		
Orthopedic / Bone		
Psychological/Psychiatric (anxiety, depression)		
Surgery		
Speech		
Vision Loss / Correction		
Other (explain below)		

Please give details and dates to all of the above marked ***YES***._____

_____

- Is the student currently under any kind of **medical care or treatment**? _____YES_____ NO

Explain_____

- Is the student taking any **medication** on a regular basis (prescription or non-prescription)? ____YES ___ NO

** Physician (Please Print) _____

Describe any **modifications or restrictions** that are necessary to accommodate your child's health or safety?

_____

CONSENT

_____ **OVER-THE-COUNTER MEDICATIONS:** The school nurse or whom the nurse has delegated has my permission to administer
(Initials) the following medication until further notice from parent or guardian (check *ALL* that you give permission for).

_____Acetaminophen (Tylenol) _____Ibuprofen (Advil, Motrin) _____Antacids (Tums)

_____Cough Drop _____Allergy (Claritin/Zyrtec) _____Excedrin Migraine (MS/HS)

Topical medications such as antiseptic wash, Neosporin, burn cream, muscle rub, antifungal cream and hydrocortisone cream or Benadryl spray are used periodically at the nurse's discretion.

IF YOU ARE SENDING ANY MEDICATION FROM HOME TO SCHOOL, PLEASE CONTACT THE SCHOOL NURSE OFFICE BEFORE SENDING!!!

_____ CONSENT **FOR MEDICAL INFORMATION:** There may be occasions on which we need to contact your physician or dentist
(Initials) for health information.

_____ Kansas **Immunization Registry**: Access immunization records online.
(Initials)

ParentGuardianSignature_____Date_____

FOR DISTRICT USE ONLY – SCHOOL NURSE

IMMUNIZATIONS

- Has the student received all of their vaccinations for the upcoming school year?
- Immunization Record □ Received □ Obtain Record □ Up to Date □ Needs Immunizations

MEDICATION FORMS

- Authorization for Medications □ Given □ Received (SN ONLY)
- Self-Administration/Carry □ Given □ Received (SN ONLY)
