



Douglas County School District – Health Services Department

HEALTH INFORMATION UPDATE

Date: _____, 20__

_____/_____/_____
Last Name First Name MI Date of Birth Teacher
() () () M F
Home Phone Daytime Phone Cell Phone Gender Grade

Father/Guardian Name

Mother/Guardian Name

Emergency Contact

Emergency Contact Phone Number

Family Physician Name

Family Physician Phone Number

CURRENT HEALTH PROBLEMS

(Please check those that apply)

- | | |
|---|--|
| ☐ NO KNOWN DISABILITY | ☐ VISUAL IMPAIRMENT |
| ☐ HAS YOUR CHILD HAD THE CHICKEN POX DISEASE? YES NO | ☐ GLASSES |
| ☐ ASTHMA/AIRWAY DISEASE | ☐ CONTACTS |
| ☐ ALLERGIES: (FOOD, INSECTS, MEDICATIONS, SEASONAL, OTHER) | ☐ HEARING IMPAIRMENT/AID |
| ☐ SEVERE REACTION TO: _____ | ☐ NEUROLOGICAL DISEASE
SPECIFIC DIAGNOSIS: _____ |
| ☐ PAST SURGERIES: _____ | ☐ MUSCULAR DISEASE |
| ☐ DIABETES | ☐ ORTHOPEDIC PROBLEM
SPECIFIC DIAGNOSIS: _____ |
| ☐ SEIZURE DISORDER | ☐ HEART PROBLEM
SPECIFIC DIAGNOSIS: _____ |
| ☐ ADD/ADHD | ☐ OTHER: _____ |

Is student able to take P.E.? Yes ☐ No ☐

Is Medication needed at school? Yes ☐ No ☐

If yes, you must fill out the Medication Assistance Request Form (on back) for all meds taken at school and this includes all prescription medications AND all over-the-counter medications

Receiving Medication at home? Yes ☐ No ☐

*If yes, name of medication(s) _____

In the event that my child _____ becomes seriously ill or injured at school, I hereby consent to have my child transported and treated as deemed necessary by school personnel and the receiving medical institution. I understand the parent/guardian is responsible for all expenses.

Parent/Guardian Signature

Date