Yearly Health Report

☐ Joel ☐ Eliot ☐ Morgan

Student: Grade: Date of Birth

1. My child can participate in all activities, including physical education.
   Yes ☐ No ☐ If no, why? _____
2. Is your child allergic to any medication? Yes ☐ No ☐ If yes, what? _____
3. Does your child have any other allergies (food, insects, latex, etc.)? Yes ☐ No ☐ **If yes, complete page 2 of this form**
4. List all medications your child is presently taking:

Medication: For what reason: Prescribed by:

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Medication: For what reason: Prescribed by:

If medication is to be given during school hours, it must be accompanied by a signed order from your healthcare provider and authorization from parent/guardian (See Form H-005A and H-005B)

5. Please notify the school nurse if your child has any of the medical conditions below:

Asthma	☐	Cerebral Palsy	☐	Chronic Headaches	☐	Urinary Problem	☐	Speech Disorder	☐
Diabetes	☐	Scoliosis	☐	Migraines	☐	Gastro-intestinal	☐	Hearing Problem	☐
Seizure Disorder	☐	Vision Problems	☐	Recurrent Nosebleeds	☐			Ear Tubes in	☐
Heart Condition	☐	If student wears glasses, when are they worn?:						Ear Tubes out	☐

Other: _____

6. List any communicable diseases your child has had during the past year:

Disease: Date:

Disease: Date:

Disease: Date:

7. Has your child had chickenpox? ☐ Yes ☐ No When? _____

** Physician-certified history of Chickenpox or serologic proof of immunity is required prior to entrance to 7th Grade.**

8. List any immunizations or boosters given to your child during the past year.

Immunization: Date:

Immunization: Date:

Immunization: Date:

9. List any serious accidents or operations your child had during the past year.

10. Date of last dental exam? _____

Parent/Guardian Home Phone: _____ Daytime Phone: _____

Signature of Parent/Guardian _____ Date _____

Signature of Nurse _____ Date _____

Complete the section below ONLY if you answered YES to Question #3 above.

Student: Grade: DOB

1. Check any allergy(ies) your child has:

☐ Insect Stings List type: _____

☐ Food List type: _____

☐ Pollens Usual time reactions occur: ☐ Spring ☐ Summer ☐ Fall ☐ Winter

☐ Animals List type: _____

☐ Dust ☐ Grass ☐ Other _____

2. Check symptoms usually present during allergy attack:

☐ Difficulty breathing ☐ Rash ☐ Difficulty swallowing

☐ Nausea ☐ Loss of consciousness ☐ Flushed or unusually pale skin color

☐ Swelling: Where? _____

3. Has medication been prescribed by a healthcare provider for your child's allergy(ies)? ☐ Yes ☐ No

If yes, list below. Please complete an Authorization for the Administration of Medicine by School Personnel Form #H-005B.

Allergy _____ Medication _____

Allergy _____ Medication _____

Allergy _____ Medication _____

4. Has hospitalization been needed in the past year for allergies? ☐ Yes ☐ No

5. Hospital preference: _____

ADVISE THE NURSE IMMEDIATELY OF CHANGES IN DOSE AND/OR MEDICATION.

The usual treatment for a severe allergic reaction is to:
- ► Assist student with the prescribed medication per written healthcare provider's order
- ► Observe the student for inadequate breathing; signs of shock, unusual swelling and if/when observed, call 911/EMS
- ► Report signs/symptoms to parent(s)/guardian(s)

Remember to advise the school immediately of changes in phone numbers, address, responsible emergency contact person(s), healthcare providers and hospital preferences.

Signature of Parent/Guardian _____ Date _____

Signature of Nurse _____ Date _____