Clinton
PUBLIC SCHOOLS

YEARLY HEALTH REPORT

(New Student Only)

Student's Name: _____ Date of Birth: _____

School: ☐ Joel ☐ Eliot ☐ Morgan Grade _____

1. The student can participate in all activities, including physical education. ☐ Yes ☐ No If no, why? _____
2. Is the student allergic to any medication(s)? ☐ Yes ☐ No

If yes, please list medication(s): _____

3. Does the student have any other allergies (food, insects, latex, etc.)? ☐ Yes* ☐ No

*If yes, complete page 2 of this form.

4. List all medications the student is currently taking: (if more room is needed, please use an additional sheet of paper)

Medication _____ Reason _____ Prescribed by _____
Medication _____ Reason _____ Prescribed by _____
Medication _____ Reason _____ Prescribed by _____
Medication _____ Reason _____ Prescribed by _____

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

5. Does the student have any of the following medical conditions? (Check all that apply)

☐ Asthma ☐ Cerebral Palsy ☐ Chronic Headaches ☐ Diabetes Ear Tubes ☐ (In) ☐ (Out) ☐ Gastro-intestinal
☐ Hearing Loss/Disorder ☐ Heart Condition ☐ Migraines ☐ Recurrent Nosebleeds ☐ Scoliosis ☐ Seizure Disorder
☐ Speech Disorder ☐ Urinary Issues ☐ Vision Issues ☐ If student wears glasses, when are they needed? _____
☐ Other _____

6. List any communicable diseases the student has had during the past year.

Disease _____ Date _____
Disease _____ Date _____
Disease _____ Date _____

7. Has the student 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 give to the student during the past year.

Immunization _____ Date _____
Immunization _____ Date _____
Immunization _____ Date _____

List any serious accidents or operations the student had, if any, during the past year. (If more room is needed, use an additional sheet)

_____

_____

Date of last dental exam? _____

Parent/Guardian Home Phone _____ Cell Phone _____

Signature of Parent/Guardian _____ Date _____

Signature of Nurse _____ Date _____

Administrative Offices | 137-B Glenwood Road | Clinton, CT 06413 | Phone: 860-664-6500 | Fax: 860-664-6580

If you answered YES to page 1 question #3, complete the section below:

Student's Name: _____ Date of Birth: _____

School: ☐ Joel ☐ Eliot ☐ Morgan Grade _____

1. Check any allergy(ies) known for the student:

☐ Insect stings Type _____
☐ Food Type _____
☐ Pollen Usual time reactions occur: ☐ Spring ☐ Summer ☐ Fall ☐ Winter
☐ Animals Type _____
☐ Dust ☐ Grass ☐ Other _____

2. Check any symptoms usually present during student's allergy attack:

☐ Difficulty breathing ☐ Rash ☐ Difficulty swallowing ☐ Nausea
☐ Loss of consciousness ☐ Flushed or unusually pale skin ☐ Swelling Where? _____

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

If yes, list medication(s) below. Complete an Authorization 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 DOSAGE 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)

ADVISE THE SCHOOL IMMEDIATELY OF CHANGES TO PHONE NUMBERS, ADDRESS, RESPONSIBLE EMERGENCY CONTACT PERSON(S), HEALTHCARE PROVIDERS, AND HOSPITAL PREFERENCES.

Signature of Parent/Guardian _____ Date _____

Signature of Nurse _____ Date _____

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