Annual Health Report
2015/2016

Dear Parents/Guardians,
In order for us to keep your child's health record up to date, we would like you to provide the following information:

Child's Name____ Date of Birth:_____________ Grade_________

For Parents of High School Students Only:
Do you wish your child to be given any of the following per request from a stock bottle in the nurse's office?

Acetaminophen (Tylenol) ☐ Yes ☐ No Ibuprofen (Advil) ☐ Yes ☐ No

Date of most recent visit to:
Family doctor:___/___/___ Name of doctor:__________________________________ Phone #:_______________
Immunization/booster in the last year? Yes____ No____ (If yes, please list type and date)
Type:____ Date:__________________

Eye doctor:___/___/____ Name of eye doctor:___________________________ New glasses or contacts?________

Accidents/illnesses/surgeries within past year: ____

Please list any medication your child takes regularly:____

If it is medically necessary for your child to have medication administered at school, please contact the school nurse so a medication permit can be sent home for the parent and doctor signature.

Please check the following conditions that apply to the student (if they are changes). Include a brief explanation and any dates where appropriate in the space below. Please notify your school nurse with any concerns/questions. Thank you.

_______ ADD/ADHD
_______ Allergic to bee stings
mild __moderate__ severe__(check one)
_______ Allergic to food (list below)
mild__moderate__severe__
_______ Allergic to medication (list below)
_______ Allergic to other (list below)
_______Arthritis
_______Asthma
_______Birth defect/Chromosome disorder
_______Blood Disorder
_______Blood/ Blood Products not given
_______Cancer/Leukemia
_______Cerebral Palsy
_______Color blind
_______Cystic Fibrosis
_______Diabetes
_______Fainting
_______Head injury/concussions
_______Heart Disease/ Defect
_______Kidney disorder
_______Lice
_______Menstrual cramps(severe)
_______Mental health issues
_______Muscular Dystrophy
_______Migraine headaches
_______Nosebleeds (frequent)
_______Osgood- Schlatter's Disorder
_______Physical activity limitations
_______Rheumatic Fever History
_______Scoliosis
_______Seizures
_______Other (list below)
_______No known health problems

Explain:____

____

It may be necessary to share health information with your child's teacher and/or coach (either verbally, in written form, or by e-mail) to ensure their safety and welfare. Please give your consent to the sharing of pertinent health information by signing below (if you have questions or concerns about this, please do not hesitate to call):

Parent/Guardian Signature____ **Today's date**_____________

Barbara Parent R.N.- School Nurse bparent@rsu22.us Office phone: 862-5570

PLEASE NOTE: If you think that your child's medical condition necessitates accommodations in school, please send in a doctor's note documenting this diagnosis to the school nurse.

REQUIRED