Sargent Public School Yearly Health Update

Name:_____ **Birthdate:**_____
First MI Last (Circle) **Sex:** M / F
(Print)
Grade:_____ **Guardians Name** _____**Date:**_____

ALERT TO PARENTS: If your child has a serious medical condition, *it is vital that you discuss this with your School Nurse and teacher(s) immediately*. The school **must** know of **LIFE THREATENING** conditions (for example asthma, diabetes, nut/insect allergies with anaphylaxis) prior to the start of school. Additional forms will be needed.

In order to provide a safe and healthy environment for your child this information will be accessible to the following people: School Nurse, Staff responsible for safety of student, and emergency medical personnel.

A. Medical History: Check the ones that apply to your child and describe under the comment section.

____ADD/ADHD
____Anxiety/Panic Attack
____Asthma ____Inhaler
____Bee Sting Allergy
____Bowel Problem
____Cerebral Palsy
____Diabetes
____Color Blindness
____Epi-Pen
____Emotional Concerns
____Headaches
____Hearing Problem
____Heart Condition
____Kidney/Urinary Problems
____Muscle Disorder
____Neurological Concern
____Orthopedic Problem
____Seizures
____Vision Problems
____Concussion:# of_____
____Food Allergy_____
List:_____
_____
_____
____Other: _____
Explain: _____
_____

Comments:_____
(Use back if needed)

B. Allergies: List allergies your child has that may cause a problem at school:

Cause of the allergy:_____ Treatment:_____

Cause of the allergy:_____ Treatment:_____

C. Medication: (Include prescription, over-the-counter and herbal medication. Use back if more space is needed)

Name:	Used to Treat:	Taken at School?
1)_____	_____	Yes ☐ No ☐
2)_____	_____	Yes ☐ No ☐
3)_____	_____	Yes ☐ No ☐

Before medication of any kind can be administered at school, a medication administration form, available in the office, must be completed by a parent and kept on file.

E. List any other operations, injuries, hospitalizations. Give Dates:_____

_____

F. Does your student wear contact lens?_____ Glasses?_____

G. Name of Physician:_____ Date of Last Appointment:_____

Name of Dentist:_____ Date of Last Appointment:_____

Name of Optometrist:_____ Date of Last Appointment:_____

Guardian Signature:_____

Guardian Phone number:_____