Complete and return this form **ONLY** if any of the below applies to your student.

Current Health Information – Annual Update

My child has the following serious or chronic health condition(s):

____ Asthma - requiring medication* or **EMERGENCY** treatment

____ Bee Sting Allergy that requires medication* or **EMERGENCY** treatment

____ Severe allergy that requires medication* or **EMERGENCY** treatment

____ Activity limitation/restriction

____ ADD or ADHD (circle)

____ Diabetes*

____ Hearing Disorder

____ Vision Disorder

____ Other Serious or Chronic Condition

____ Heart Condition

____ Urinary System Disorder

____ Muscular/Skeletal Disorder

____ SEVERE Environmental Allergy

____ Seizure Disorder

Explain _____

_____

* Contact the school nurse for the required medication and/or physician authorization forms.

Medications

List all prescribed medications taken on a daily basis at home _____

List all prescribed medications that will be taken daily at school _____

Please refer to the student handbook for rules regarding medication at school. Students in Pre- K through 12th grade must have authorization from the licensed prescriber for all prescription medication. Over the counter medications require prescriber authorization for students in Pre-K through 6th grade only. Over the counter medications may be self administered by students in grades 7-12 following the guidelines in the student handbook.

Student: _____ Date: _____

School: _____ Grade: _____ Teacher/Team: _____

Parent (s) Names: _____ Home Phone: _____

Work Phone: _____ Cell Phone: _____

I would like to conference with the school nurse. _____ Yes or _____ No

I understand that this health information may be shared with school staff.

Parent/Guardian Signature: _____

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