ANNUAL HEALTH UPDATE

Return to School Nurse

NAME_____GRADE____SCHOOL_____YEAR____

PLEASE COMPLETE CONFIDENTIAL HEALTH INFORMATION TO BE SHARED WITH TEACHING STAFF

Does your child have asthma? Yes / No
If yes, please state care:

_____

Has your child been diagnosed hyperactive? Yes / No

Does your child have a seizure disorder? Yes / No

Does your child have diabetes? Yes / No

Does your child have any allergies to foods, insects or other? Yes / No
If yes, please list and state care:

_____

Does your child take daily medications as prescribed by a physician? Yes / No
If yes, please list medication, dosage and time of administration:

_____

Does your child wear glasses? Yes / No
If yes, state fulltime wear or reading glasses only: _____

Does your child have restrictions in activity as ordered by a physician? Yes / No
Please list:

_____

***PLEASE LIST ANY OTHER HEALTH CONCERNS YOU HAVE FOR YOUR CHILD.

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