Name:______________________________________
Last First M.I.

St. Charles City School District
STUDENT HEALTH UPDATE

School ____________________ Birthdate____________
Year ____________ Grade ______ Male ____ Female ______

Please complete the following information which will assist us in providing your child's school health services and educational needs in a safe and effective manner.
Return this form to the School Nurse.

Address:______________________________ Phone:______________ Lives with: ______________

Father's Name:______________________ Work Phone:______________ Cell Phone:______________

Mother's Name:______________________ Work Phone:______________ Cell Phone:______________

Step Parent: ______________________ Phone:______________ **Parent Email:**______________

Current Doctor:______________________ Phone:______________ Fax:______________

Emergency Contacts: (1)______________________ Phone:______________ (2) ______________ Phone: ______________

DOES YOUR CHILD HAVE:

Allergies?

Drugs:____________________

Food: ex: peanuts____________

____

____

Bee Sting:____________________

Pollens:____________________

Other:____________________

Life threatening Allergy?: ___YES ___ NO
If YES, SEE NURSE

Must provide emergency medicine if required for use at school.)

Asthma? NO / YES **If YES, SEE NURSE**

Diabetes? NO / YES **If YES, SEE NURSE**

Epilepsy/Seizures? NO / YES **IF YES, SEE NURSE**
Describe: ____________________

Heart Condition? NO / YES Describe: ____________________

Physical RestrictionS? NO / YES Describe: ____________________

Physical Handicap? NO / YES Describe: ____________________

Condition that prevents full participation in PE?: ***Doctor note required*

List surgeries (operations): ____________________

Emotional conditions: ____________________

Other health info / concerns: ____________________

Revised 11/11

✓ or circle ***THE FOLLOWING REGARDING HEALTH CONCERNS***

Eyes: glasses___ (reading___ distance___); contacts___; crossed___; lazy eye___; difficulty seeing___; color blindness___.

Ears: frequent infections___; tubes___; hearing difficulty___ (explain)
____
Hearing aid___ (right___ left___) Wear at school? YES NO

Medications: Takes daily medications at home? YES NO
Takes daily medications at school? YES NO

List current medicine taken at home-include dosage and time of day given:

(1):____________________

(2):____________________

(3):____________________

- ***If student requires medication at school please obtain the appropriate form from the school nurse or the school website.***
- ***Medication left in the clinic will be thrown away on the last day of school.***

**All updated immunizations require signature of physician or health department with day, month and year.*

The information provided above will be shared as needed with school staff to provide for the health and safety of my child. If I or an authorized emergency contact cannot be reached in an emergency, I authorize school staff to obtain emergency medical care as needed. I understand I will assume financial responsibility for any medical services rendered.

____
Signature of legal parent/guardian Date