PLEASE PRINT CLEARLY

# ANNUAL HEALTH INFORMATION UPDATE

*Information is confidential and used only by the nurse to make medical decisions in the child's best interest.*

STUDENT'S **"LAST"** Name:_____ **"FIRST"** Name: _____
(PRINT CLEARLY) (PRINT CLEARLY)

**Date of Birth:** _____ **Gender:** ____ **Male** ____ **Female** **Grade Level:** _____

**Physician:** _____ **Office Number:** _____

**Dentist:** _____ **Office Number:** _____

**Insurance:** _____ Medicaid _____ Other _____ None

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**Medication:** _____ Home _____ School _____ Daily _____ As needed _____ Emergency only

**Medicine name:** _____ Dose: _____ Time(s): _____ Reason: _____

**Medicine name:** _____ Dose: _____ Time(s): _____ Reason: _____

**Medicine name:** _____ Dose: _____ Time(s): _____ Reason: _____

**EYES:** ____ Glasses _____ Contacts ____ Reading ____ Distance ____ Lazy Eye ____ Difficulty seeing

**EARS:** Infections **R / L** Tubes **R / L** Hearing difficulty **R / L** Hearing Aid—wear at school? **Y /N**

**Comments for Nurse:**

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**If ANY CONDITION(S) IS/ARE INDICATED BELOW, CALL SCHOOL NURSE AT 636.923.3634.**

**ALLERGIES:** __No ____**YES** If yes, list triggers: _____

**IMPORTANT: DOES STUDENT NEED TO SIT AT "PEANUT-FREE" TABLE:** ___ No _____**YES**

**DIABETES:** __No _____**YES** **SEIZURES:** ___ No _____ **YES**

**ASTHMA:** __No _____**YES** **DAILY MEDICATION:** ___No _____**YES**

**OTHER:** _____

**Comments for Nurse:**

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**In case parent/legal guardian can't be reached – call the following emergency contacts:**

1st:_____ Relationship: _____ Home/Cell#: _____ Work:_____

2nd:_____ Relationship: _____ Home/Cell#: _____ Work:_____

3rd:_____ Relationship: _____ Home/Cell#: _____ Work:_____

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**Parent/Legal Guardian Signature** **Date**