

STUDENT HEALTH INFORMATION UPDATE

Name of Student: _____ Grade: _____

Has your child received any immunizations or booster shots?
() yes - Please attach copy of shot record & return to the Nurse.

Has your child had a Vision or Hearing exam? Date: _____

Results: _____

() Glasses () Contacts

Has your child developed any new Allergies? List: _____

Does your child have or been recently diagnosed with any illnesses or medical conditions not reported on the Student Health Record completed at the beginning of the year? () yes - Explain below

Has your child had any recent Surgeries or Hospitalizations? () yes- Explain below

Has your child had any outside evaluations such as medical, neurological, cardiac, orthopedic, psychiatric, psychological, or special test you'd like to report? () yes -- Explain below.

Has your child been started on any prescription medications? List below

Please list any new family changes, special health problems/behaviors or other concerns that you have regarding your child.

I would like the School nurse contact me about a special concern.

Phone number you can be reached at: _____

Parent Signature: _____ Date: _____

** All Information on this form shall be held in confidence.